



Child Screening Questionnaire

Date: _____

Name: _____ Phone: _____

Child: _____ Age: _____ Email: _____

Is there any history of learning difficulties in your immediate family? Yes No

Were there any medical problems during the pregnancy? Yes No

Was the birth process unusual or prolonged in any way? E.g. Caesarean, Forceps, Breech etc. Yes No

Was your child born early or late for term (more than 2 weeks early or more than 10 days late)? Yes No

Was your child's birth weight below 5lbs (pounds)? Yes No

Did your child have any difficulty feeding in the first weeks of life, or in keeping food down? Yes No

Was your child extremely demanding in the first 6 months of life (cry, fussy, difficult to settle)? Yes No

Did your child miss out the motor stage of crawling on his or her tummy or crawling on hands and knees? Yes No

Was your child late at learning to walk (16 months or later would be considered late)? Yes No

Was your child late at learning to talk (2-3 word phrases at 18 months or later would be considered late)? Yes No

Did your child have difficulty in learning to dress himself or herself ie, doing up buttons, clothes backwards or tying shoelaces beyond the age of 6-7 years?	Yes No
Does your child suffer from allergies?	Yes No
Did your child have an immune reaction that you are aware of to any of his or her vaccinations?	Yes No
Did your child suck his or her thumb beyond the age of 5 years?	Yes No
Did your child continue to wet the bed, occasionally or frequent, above the age of 5 years?	Yes No
Does your child suffer from travel sickness?	Yes No
Did your child find it very difficult to learn to tell the time from a traditional (as opposed to digital) clock?	Yes No
Did your child have significant difficulty learning to ride a bicycle?	Yes No
Did your child suffer from frequent ear, nose, throat or chest infections at any time in development?	Yes No
In the first 3 years of life, did your child suffer from any illnesses involving extremely high temperatures, delirium or convulsion?	Yes No
Does your child have difficulty catching a ball, doing a forward roll/somersault and/or seem awkward in PE class?	Yes No
Does your child have difficulty sitting still for even a short period of time?	Yes No
If there is a sudden unexpected noise, does your child over-react?	Yes No
Does your child experience stress when doing schoolwork?	Yes No
Does your child have any reading difficulties?	Yes No

