DEVELOPMENTAL CONCERNS SCREEN

Chief Concern(s): _____

_____

At what age were you first concerned? _____

Developmental History:
History of losing skills – ex: walking, talking, pointing (circle)? Yes / No

Gross Motor:
At what age did your child sit and walk? _____
Any toe walking (circle)? Yes / No

Fine Motor:
Check what your child can do:

- Use thumb and pointer finger to pick up small objects _____
- Feed self with spoon or fork _____
- Dress/Undress self _____
- Write with ease _____
- Manage round doorknobs or open small candies / buttons _____
- Potty trained _____

Language:
How many words does your child have total? ____ words
Check what your child can do:

- Combine 2 words together _____
- Speak in 3-4 words phrases _____
- Understand instructions _____
- Make odd noises _____

Social history:
Check what your child can do:

- Smile back at you _____
- Sustain eye contact when you talk to or look at him/her _____
- Point with finger towards what he/she wants _____
- Bring objects to show you or want you to play with him/her _____
- Play with toys appropriately _____
- Respond / turn to you when you call his/her name _____

Prefers to (circle):

- Play alone / Play with others

Repetitive Movements:
Check if your child does any of the following:

- flaps hands _____
- brings hands close to eyes and moves them around _____
- spins _____
- rocks body _____
- head bangs _____
- constantly needs to move around _____

Any other repetitive movements? _____

Limited Interests:
Any obsessions (1-2 objects that he/she must have or talk about) (circle)? Yes / No
Lines up objects or constantly flips them (circle)? Yes / No

Attached to unusual objects (rock, string, etc.) (circle)? Yes / No
Any problems transitioning between activities (circle)? Yes / No

Disturbing Behaviors:
Any other concerning behaviors? Yes / No _____

Sleep:
Any problems with sleep? Yes / No

Diet:
Picky eater? Specific textures avoided (mushy, crunchy)? Yes / No

Seizure History:
Any history of seizures? Yes / No
Any spells of unresponsiveness? Yes / No

Current Interventions:
Has your child started the following therapies? If yes, at what age?

- Speech _____
- Occupational _____
- Behavioral _____
- Physical _____
- ABA therapy _____

Previous Workup and Results:
Hearing test / Vision test
EEG / MRI Brain / CT Scan
Genetic Testing