For office use only:
Date Sent______________
Date Received______________

Griffin-Spalding County Schools
Special Needs Preschool Program
Developmental Evaluation Referral Questionnaire

GENERAL INFORMATION

Child's Name:_____________________________ ___________________ Date of Birth:________ Age:______
(First) (Middle) (Last)

Sex: (circle) Male Female Social Security Number: _________________________________

Home Address:____
(Street) (City) (Zip Code)

Home Phone Number: ______________________________ Alternate Number:_________________________

Email Address: ____

Neighborhood Elementary School: ____

Referred By: ____________________________________ Relationship: ______________________________
Address: _______________________________________ Phone Number: ______________________________

Person completing form: (circle) Mother Father Stepmother Stepfather Other:________________

Reason for referral (describe what concerns you most about your child and your reason for referral: __________
____

How long has the problem(s) been of concern to you? ____
Goals for your child: ____
____

Describe your child's favorite activities, toys, and interests: ___________ ______________________________
____

Does your child attend: ___Daycare ___ Preschool ___ Lottery Funded Pre-K ___Head Start ___Early Intervention Program

Name/Address of the above:____

Mother's Name: ________________ _____________Age: ___________ Education: ______________________
Occupation: _______________________Home Phone # _____________Work Phone # ___________________
(___ Biological ____Adoptive ___Step ____Foster ___Guardian)

Father's Name: ___________________ ___________Age: ___________ Education: ______________________
Occupation: _______________________Home Phone # _____________Work Phone # ___________________
(___ Biological ____Adoptive ___Step ____Foster ___Guardian)

Child lives with: (circle) Both Parents Mother Father Other:___________________________________
Marital Status of Parents: (circle) Married Separated Divorced Widowed Single
If parents are separated or divorced, how old was child when this occurred? _________

Primary language spoken at home: ____
Other language spoken in the home: ____

List all siblings/other relatives, foster children, friends currently living in household:

Name *Relationships to the child* *Age*

____
____
____
____
____
____

If any brothers or sister are living outside the home, list their names and ages: ____________________________
____

Has your child been diagnosed with any syndromes or medical conditions? Yes No
If yes, please list or describe: ____
____
____
____

Has your child ever been exposed to heavy metals, such as iron, mercury, plutonium, etc.? Yes No
If yes, what metal? ____

Has your child ever been diagnosed with lead poisoning? Yes No
If yes, please explain.
____
____

Please check any condition that any member or the immediate family has had. Please not the member's relationship to the child.

Condition:	*Relationship to the child:*
__Learning Problems	____________________________
__Speech/Language Disorder	____________________________
__Attention Deficit Disorder	____________________________
__Hearing or Vision Impairment	____________________________
__Other ( )	____________________________

PREGNANCY/BIRTH HISTORY

During pregnancy:
Was mother on medication? YES NO
(If yes, describe:____________________________________)

Did mother smoke? YES NO
Did mother drink alcoholic beverages? YES NO
Did mother use drugs? YES NO
(If yes, list: ____)
Did mother experience problems with: ___chronic disease __poor nutrition __trauma
___ vaginal bleeding __toxemia __viral infection
___premature labor __hypertension
___gestational diabetes ____other _____________
Were forceps used during delivery? YES NO
Was vacuum suction used during vaginal delivery? YES NO

PREGNANCY/BIRTH HISTORY (continued)

Was a Cesarean Section performed? YES NO
(If yes, state reason ______________________________)
Was the child breech (feet first)? YES NO
Was the child premature? YES NO
(If so, by how many weeks __________________________)

Were there any birth complications? YES NO
If yes, please describe: ____
____
____
Was there any special care needed following birth? ___incubator ____ oxygen ____monitors ___other
If other, please describe: ____
____
____
Birth weight:_____________ Birth length: ________________
Was baby discharged with mother? YES NO
If no, how long was the baby hospitalized? ____

Were there any feeding/swallowing problems? YES NO
If yes, please describe: ____
Were there any sleeping problems? YES NO
If yes, please describe: ____
As an infant, was the child more quiet than typical? YES NO
Did the child like to be held? YES NO
Was the child alert? YES NO
Were there any special problems during the first few years of life? YES NO
If yes, please describe: ____

DEVELOPMENTAL HISTORY

The following is a list of infant and preschool behaviors. Please indicate the **age** at which your child demonstrated each behavior. If you are not certain of the age, but have some idea write the age followed by a question mark.

Behavior	Age	Behavior	Age
Showed response to parent	____	Put several words together	____
Rolled over	____	Fed self	____
Sat alone	____	Dressed self	____
Crawled	____	Became toilet trained	____
Walked alone	____	Stayed dry at night	____
Babbled	____	Rode tricycle	____
Spoke first word	____		

MEDICAL/HEALTH INFORMATION

Please specify any of the following that apply to your child's medical history:

Illness/Condition	Age	Illness/Condition	Age
Allergies	____	Cleft Palate/Lip	____
Asthma	____	CMV	____
Bleeding Disorder	____	Concussion	____
Cerebral Hemorrhage	____	Craniofacial Deformities	____
Chronic Colds	____	Diabetes	____
Chronic Ear Infections	____	Ear Tubes/Surgery	____
Encephalitis	____	Fragile X	____
Fevers over 104 degrees	____	Genetic Disorders	____
Head Injuries	____	Heart Problems	____
Shunts	____	Sinus	____

MEDICAL/HEALTH INFORMATION **(continued)**

Illness/Condition	Age	Illness/Condition	Age
Spina Bifida	____	Sickle Cell Anemia	____
Meningitis	____	Tremors (location:________)	____
Vocal Nodules	____	Tonsillitis	____
Other: ______________	____	______________	____
______________	____	______________	____

List any additional operations, hospitalizations, or injuries your child has had:

AGE

____ ____

____ ____

____ ____

Does your child use any assistive/adaptive devices? ___glasses ___braces ___wheelchair
___walker/crutches ___hearing aid ___other: (Please specify _________________________________)

Please list any medication your child is presently taking:

Medication	Dosage	Reason for Taking
___________________________	___________________	________________________
___________________________	___________________	________________________
___________________________	___________________	________________________
___________________________	___________________	________________________
___________________________	___________________	________________________
___________________________	___________________	________________________

MEDICAL/OTHER SERVICE PROVIDERS

Pediatrician _________________________________ Phone: ___________________________

Cardiologist _________________________________ Phone: ___________________________

Neurologist _________________________________ Phone: ___________________________

Gastroenterologist ____________________________ Phone: ___________________________

ENT _______________________________________ Phone: ___________________________

Orthopedist _________________________________ Phone: ___________________________

Psychologist/Psychiatrist ________________________ Phone: ___________________________

Ophthalmologist ______________________________ Phone: ___________________________

			Start Date	End Date
Physical Therapist ___________________________	Phone: _____________		_______	_______
Occupational Therapist _______________________	Phone: _____________		_______	_______
Speech/Language Therapist ____________________	Phone: _____________		_______	_______
BCW Service Coordinator ______________________	Phone: _____________		_______	_______
Other: ______________________________________	Phone: _____________		_______	_______

(e.g. Special Instruction, Behavior Therapy, Music Therapy)

LANGUAGE/MOTOR/BEHAVIOR/COGNITIVE DEVELOPMENT

Please indicate which of the following describes your child and/or concerns you:

___Speech /Language Difficulty

___Gestures/points instead of using words
___ Speech appeared to develop and then stopped
___ Uses babbling (baba, dada)
___ Stuttering
___ Hoarseness
___ Other ____

___Uses jargon (unrecognizable words)
___ Inability to produce speech sounds
Specify: _________________________
___ Inability to follow directions
___ Inability to understand words/sentences

___Unable to repeat 2, 3, 4 word phrases
___Inability to be understood
___Not combining words into sentences
___ Difficulty answering questions

Please indicate the number of words your child uses spontaneously
__0-10 ___10-20 ___20-50 ___50-100 ___more than 100 ___too many to count How many signs: ___
(*If your child uses less than 50 words or signs, it would be helpful if you brought a list of those words to the evaluation.)*

Please describe how your child's speech/language difficulties affect his/her daily life:
____
____
____
____

____ Motor Concerns

___ Difficulty with coordination
___ Difficulty walking, running
___ Clumsiness
___ Difficulty eating

___Inability to sit without support
___ Falls/trips frequently
___ Difficulty dressing, buttoning zipping
___ Difficulty using pencils, crayons, scissors

___ Difficulty with puzzles/Manipulative toys
___ Difficulty with balance, jumping, hopping
___ Difficulty negotiating stairs, curbs, playground

___ Other ____

___ Behavior/Social Concerns

___Bullies other children
___Prefers to be alone
___Is inattentive
___Is impulsive
___Cries easily
___Is obedient
___Is cruel to animals/people

___Is shy or timid
___Is aggressive
___Restless/difficulty sitting still
___Has frequent tantrums
___Tells lies
___Worries about many things
___Unhappiness/sadness

___Difficulty with changes or routines
___Highly sensitive to sounds
___Highly sensitive to textures
___Distracted by lights or visual stimuli
___Insensitive to pain
___Plays repetitively with certain toys
___Mouths toys frequently

___Bites nails/fingers
___Easily frustrated
___Is stubborn
___Unusual fears
___Will not work in a group
___Destroys others' belongings
___Seeks out rocking, spinning, swinging
___Fussy or over particular
___Difficulty playing with other children
___Is noncompliant
___Gives up easily
___Doesn't have any friends
___Having behavior difficulty at school
___Twitches/mannerisms/tics of face or body
___Does not separate easily
___Head banging
___Biting
___Kicks, bites, hits others
___Has wet/soiled this year

____Other: ____

___Cognitive Concerns

____Inability to imitate simple games (pat-a-cake, peek a boo)
____Difficulty ___learning ABC's___ rote counting___ matching/naming: ___colors ___shapes
____Difficulty understanding a variety of concepts such as "big/small", "same/different", etc.
____Difficulty following instructions related to daily routines
____Difficulty following simple directions
____Does not seem to understand well
____Does not appear to be learning as well as other children
____Other: ____

___Hearing Concerns

Do you have any hearing concerns? If yes, explain: ______________________________ Yes No
____
____

___Vision Concerns

Do you have any vision concerns? If yes, explain: ______________________________ Yes No
____
____

- **Please include copies of any medical, therapy, or private reports or evaluations that might be helpful in our evaluation of your child.**

If you have any questions or need assistance in any way, please call Margaret Faulk at 770-229-5927.

Please submit documents to:

Griffin-Spalding County School System
Special Needs Preschool Program
Attention: Margaret Faulk
216 South Sixth Street
Griffin, Georgia 30224
Office 770-229-5927