INPP THE INSTITUTE FOR NEURO-PHYSIOLOGICAL PSYCHOLOGY
Licentiate

email to info@drpaat.com

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

Does your child have writing difficulties? Yes No

Does your child have copying difficulties? Yes No

Has your child had a diagnosis? Yes No

Please describe your child's specific learning concerns, and or frustrations that your child is dealing with, as well as any observations that have been made by yourself or a teacher that are not listed above.