



Family History Questionnaire

Confidential

This form is designed to give the staff at Step by Step School an overview of your child and his/her development needs. We suggest that you read through the whole questionnaire as it is quite detailed before beginning to answer any of the questions.

The questionnaire is divided into three sections: the first has questions on your family's personal details, the second concerns your child's schooling and the third section relates to your child's developmental history. Each development section asks questions about your child's **current** behaviours and abilities. At the end of each development section, there is a space for comments. It would be helpful if you would briefly summarise your child's behaviour and abilities before you noticed a "regression". If you have any queries relating to the questions, please do not hesitate to contact our ABA Supervisor.

It is our aim to provide places for children with varying abilities. We ask that you answer the questions as candidly as possibly. Thank you.

PERSONAL DETAILS

Child's details

Child's full name:

Child's nickname:

Date of birth: Sex: Male / Female

First language spoken in home:

Family details

Mother's name:

Father's name:

Address:
.....
.....
.....

Home telephone no:

Fax no:

Mother's mobile no:

Father's mobile no:

Email address(es):

.....



Occupations

Mother:

Mother's work telephone no:

*Employer:

Father:

Father's work telephone no:

*Employer:

* Details required in case of emergency.

Marital Status (please circle)

Married / Living together

Separated

Single

Divorced

Child is living with (please circle)

Both parents

Father

Mother

Other (please state):

Siblings

No. of siblings:

Name:

Age:

Sex: M / F

Name:

Age:

Sex: M / F

Name:

Age:

Sex: M / F

Name:

Age:

Sex: M / F

Have any of your other children been diagnosed with a related developmental disorder? Yes / No

If yes, please give details:

.....
.....
.....

Medical (include contact information)

Child's GP:

Child's paediatrician:

Diagnosis:

Date of Diagnosis:

Diagnosis provided by:



Additional medical conditions:

.....
.....
.....

Please list any medication your child is currently taking:

.....
.....

Diet

Is your child particular about food? Yes / No

.....
.....

Is your child on a special diet? Yes / No

.....
.....What first alerted you to change his/her diet?

.....
.....What changes have you seen since starting the special diet?
.....
.....

Statement of Special Needs

Has your child been "statemented"? Yes / No

If yes, please give details including date of statement:

.....
.....
.....

CHILD'S SCHOOLING

Is your child currently attending a nursery or school? Yes / No

.....
.....

If yes, how often does your child attend?

.....

Is the nursery or school a special needs provision or mainstream?

.....

Current or previous interventions

Applied Behaviour Analysis

Is your child currently on an ABA programme? Yes / No

If no, please move onto "Alternative Therapies".

If yes, please give start date:

How many hours per week is your child currently receiving?

Is he/she on a home programme or attending an ABA school?

.....Who is your current service provider?

Please give the names of your:

ABA Consultant/Senior Supervisor:

Supervisor (where applicable):

Please list some of programmes that your child is currently mastering:

.....

Please list and attach any relevant reports (for example, Educational Psychologist's reports, SALT reports):

.....

CHILD'S DEVELOPMENTAL HISTORY

General

At what age did your child begin to:

Sit: Walk:

Babble: Speak:

Eat solids: Sleep through the night:

Further comments:

.....



Social Skills

Does your child make eye contact? Yes / No

If yes, please give details (for example, when his/her name is called or he/she gives fleeting glances when requesting food):

.....
.....Does your child turn his/her head in your direction if you call his/her name? Yes / No

.....
.....
Is he/she able to sit on a chair or at a table for any length of time? Yes / No

.....
.....
Is your child aware of you entering or leaving a room? Yes / No

.....
.....
Will he/she play with you or his/her siblings? Yes / No

.....
.....
Will he/she tolerate other children playing next to him/her? Yes / No

.....
.....
Is he/she willing to share his/her special toys? Yes / No

.....
.....
Further comments:

Play Skills

Does your child show an interest in a variety of toys? Yes /No

.....
.....



Does he/she play appropriately with toys? Yes /No

.....
.....

What is his/her favourite play/toy or "downtime" activity?

.....
.....

Does he/she imitate or attempt to imitate other's play? Yes / No

.....
.....

Does he/she initiate play in any form? Yes / No

.....
.....

Has your child displayed any gross or fine motor difficulties when playing? Yes / No

.....
.....

Are there any toys or types of play that your child has a visible aversion to? Yes /No

.....
.....

Further comments:

.....
.....

Speech

Does your child say any recognisable words? Yes / No

If no, does he /she babble? Yes / No

How much is he/she currently babbling?

.....
.....

If yes, how many words can your child say?

Does he/she say them spontaneously or does he/she require prompting?

.....
.....

Please list some of the words your child may say:

.....
.....
.....

Who is able to understand your child's speech?

.....
.....



Has your child lost words or phrases he/she was once able to say?

.....
.....

If yes, has he/she regained any?

.....
.....

Further comments:

.....
.....

Language

Does your child understand single words?

Yes / No

.....
.....

Does he/she understand simple phrases/instructions?

Yes / No

Does he/she understand simple phrases/instructions?

.....
.....

Is he/she able to identify objects?

Yes / No

.....
.....

Is he/she able to label these objects?

Yes / No

.....
.....

Does your child use words to label these objects?

Yes / No

Does your child use words to label these objects?

.....
.....

If no, does he/she use consistent sounds for specific objects?

Yes / No

.....
.....

Does your child use any of the following to communicate (please circle):

PECS

Makaton

Sign Language

Other (such as gestures):

If yes, how "fluent" is your child?

Further comments:

.....
.....



Emotional Behaviour

Does your child enjoy being hugged or tickled? Yes / No If yes, by whom?
.....
.....

Does he/she initiate any social interaction? Yes / No If yes, how?
.....
.....

Does he/she display separation anxiety? Yes / No
.....
.....

When anxious or upset, how would he/she typically react?
.....
.....

Do you feel that your child has a concept of fear? Yes / No
.....
.....

Further comments:
.....
.....

Behaviour when upset

How does your child typically demonstrate frustration?
.....
.....

What situations would frustrate your child?
.....
.....

Does he/she ever react by having a tantrum? Yes / No
.....
.....

If yes, what types of situations trigger the tantrums?
.....
.....

How frequently may your child have a tantrum?
.....
.....

How would you best describe a typical tantrum (please circle):
Very upsetting to both child and parent Very long, lasting up to minutes
Varies but usually moderate Child calms down within 5 to 10 minutes
Mild, for example a little crying Resolved quickly (in a few minutes)



How is the tantrum typically resolved?

.....
.....

Is he/she physically aggressive towards others? Yes / No

.....
.....

Does he/she display self-injurious behaviour? Yes / No

.....
.....

What concerns you most about your child's behaviour?

.....
.....

How does your child's behaviour affect your family life?

.....
.....

Further comments:

.....
.....

Self-Stimulatory & Sensory Behaviours

Does your child exhibit any repetitive behaviour? Yes / No

.....
.....

Does he/she exhibit any ritualistic behaviour? Yes / No

.....
.....

Is any of your child's self-stimulatory behaviours play related, for example, your child may have a fascination with a favourite video and character? Yes / No

.....
.....

Further comments (for example, has his/her diet affected the degree of self-stimulatory behaviour):

.....
.....

Does your child show signs of being "tactile defensive", for example, dislikes being touched or the feeling of clothing/water/sand against his/her skin? Yes / No

.....
.....

Does he/she exhibit sensitivity to noise? Yes / No

.....
.....



Does your child react typically to pain, or hot and cold? Yes / No

.....
.....

Self-Help Skills

Please list any self-help skills your child can do independently, for example, feeding, dressing or undressing, brushing teeth, toileting and so on:

.....
.....
.....

Are there any self-help skills your child attempts but finds difficult? Yes / No

.....
.....

Are there any self-help skills your child refuses to participate in? Yes / No

.....
.....

Is your child toilet trained? Yes / No / Partially, requires a nappy during the night

.....
.....

Does he/she drink from a cup? Yes / No

If no, what does he/she use?

Does your child continue to sleep through the night? Yes / No

.....
.....

Does he/she sleep in his/her own bed? Yes / No

.....
.....

Does he/she have a nap during the day? Yes / No

What self-help skills would you most like to see your child do at the moment?

.....
.....

Thank you.

Please print name:

Signature:

Relation to child:

Date: