NEURO-DEVELOPMENTAL REFLEX QUESTIONNAIRE

Name of Child _____ Date of Birth_____

Address _____

_____

Parent/Guardian Names _____

Home No. _____ Cell No. _____ Other No. _____

Email _____

Has a diagnosis been given at any time i.e. Dyslexia, Dyspraxia, ADHD, ADD? If so, please state:

_____

_____

_____

Is your child currently taking any prescribed medication? Please specify:

_____

_____

What investigations/ interventions has your child received in the past?

_____

_____

_____

_____

_____

Part 1 – Neurological

Historical Infancy

What are the presenting symptoms?

_____

_____

Please circle as appropriate

1. Is there any history of learning difficulties in either parent or their families? Yes No
2. Was your child conceived as a result of IVF? Yes No
3. When you were pregnant, did you have any medical problems? Yes No
   e.g. High blood pressure, excessive vomiting, threatened miscarriage, severe viral infection, severe emotional stress, please state:
   _____
   _____
   a. Did you smoke during pregnancy? Yes No
   b. Did you drink alcohol during pregnancy? Yes No
   c. Did you have a bad viral infection in the first 13 weeks of your pregnancy? Yes No
   d. Were you under severe emotional distress at any time, but particularly in the first 12 weeks of your pregnancy? Yes No
4. Was your child born approximately at term, early for term, or late for term? Please give details _____
   _____
   _____
5. Was the birth process unusual or difficult in any way? If yes, please give details Yes No
   _____
   _____
6. When your child was born, was he/she small for term? Yes No
   Please give birth weight if known _____
7. When he/she was born, was there anything unusual about him/her? i.e. the skill distorted, heavy bruising, definitely blue, heavily jaundiced, covered with a calcium-type coating or require intensive care. If yes, please give details Yes No
   _____
   _____
8. In the first 13 weeks of your child's life, did he/she have difficulty in sucking, feeding problems, keeping food down, or colic? Yes No
   a. Was your child breast fed? Yes No
   b. How long was your child breast fed for? _____
9. In the first 6 months of your child's life, was he/she a very still baby, so still that at times you wondered if it was a cot death? Yes No
10. Between 6 months and 18 months, was your child very active and demanding, requiring minimal sleep accompanied by continual screaming? Yes No

11. When your child was old enough to sit and stand up in the crib, did he/she develop a violent rocking motion, so violent that the crib actually moved? Yes No
12. Did your child become a "head-banger" i.e. bang his/her head deliberately into solid objects? Yes No
13. Was your child early (before 10 months) or late (later that 16 months) at learning to walk? _____
14. Did he/she go through the developmental stage of crawling on his/her tummy? (commando crawling) Yes No
15. Did he/she go though the motor developmental stage of creeping on hands and knees? Or was your child a bottom shuffler, or simply one day stood up and walked? Yes No
16. Was your child late at learning to talk? (2-3 word phrases by 2 years) Yes No
17. In the first 18 months of life, did your child experience any illness involving high temperatures and/or convulsions? If yes, please give details Yes No

    _____

    _____
18. Was there any sign of infant eczema or asthma? Yes No
    a. Was there any sign of other allergic responses? Yes No
19. Was there any adverse reaction to any of the childhood immunizations? Yes No
20. Did your child have difficulty learning to dress him/herself, and/or especially after any illness? Yes No
21. Did your child suck his/her thumb through to 5 years or more? Yes No
    If so, which thumb? Left Right
22. Did your child wet the bed, albeit occasionally, above the age of 5 years? Yes No
23. Does your child suffer from travel sickness? Yes No

Education

24. When your child first went to school, did he/she have problems learning to read? Yes No
25. In the first 2 years of formal schooling did he/she have problems learning to write? Did he/she have problems learning to do 'joined-up' or cursive writing? Yes No
26. Did he/she have difficulty learning to tell the time from a traditional clock face as opposed to a digital clock? Yes No
27. Did he/she have difficulty learning to ride a two-wheeled bicycle? Yes No
28. Was or is he/she an Ear, Nose, and Throat (ENT) child, i.e. suffer numerous ear infections, is a 'chesty' child or suffer from sinus problems? Yes No
29. Did/does your child have difficulty in catching a ball, i.e. eye-hand coordination problems? Yes No
30. Is your child one who cannot sit still, i.e. hast 'ants-in-the-pants' and is continually being criticized by teachers? Yes No
31. Does your child make numerous mistakes when copying from a book? Yes No
32. When your child is writing an essay or news item at school, does he/she occasionally put letters back to front or miss letters or words out? Yes No
33. If there is a sudden, unexpected noise or movement, does your child over-react? Yes No
34. Does your child receive educational support at school? □ IEP □ IFSP □ 504 □ No support

List support services & other relevant information:

_____

_____

_____

Part 2 Nutritional

Has your child suffered from any of the following at regular intervals?

1. Gastro intestinal problems
    a. Colic Yes No
    b. Tummy pains or wind Yes No
    c. Unusual bowel patterns Yes No
    d. Recurrent diarrhea Yes No

2. Skin Problems
    a. Eczema Yes No
    b. Dry patches on face or arms Yes No
    c. Nutmeg grater skin on upper arm Yes No
    or thigh (little tiny bumps) Yes No
    d. Dermatitis Yes No

    Anything else, please specify :

3. Ear, Nose, and Throat
    a. Mouth ulcers Yes No
    b. Bad breath Yes No
    c. Tonsillitis Yes No
    d. Earache Yes No
    e. Sinusitis Yes No
    f. Persistent runny nose Yes No
    g. Snoring Yes No
    h. Mouth breathing Yes No
    i. Hay fever Yes No

4. Asthma – Induced by:
    a. Exercise Yes No
    b. Infection Yes No
    c. Dust Yes No
    d. Mould Yes No
    e. Animals Yes No
    f. Food Yes No

5. Does your child suffer from excessive thirst? Yes No
    Do his/her symptoms get worse if he/she has more than a 2-3 hour interval without eating? Yes No

    Are there any particular foods which alter his/her behavior? If yes, please specify:

Part 3 Vision

Has your child received a developmental vision exam? Yes No
Approximate date of last exam_____

Has your child participated in a program of vision therapy? Yes No
If so, prescribed by Dr._____
Approximate date of vision therapy program_____

Anything else, please specify:

Part 4 Auditory

Developmental History

1. Was there a delay in motor development? Yes No
2. Was there a delay in language development? Yes No
3. Did your child suffer from recurring ear infections? Yes No
4. Has your child ever been investigated specifically for hearing disabilities? Yes No

Receptive Listening

This is the listening that is directed outward. It keeps us attuned to the world around us. Do any of the following apply to your child?

1. Short attention span Yes No
2. Distractibility Yes No
3. Oversensitive to sounds Yes No
4. Misinterpretation of questions Yes No
5. Confusion of similar sounding words, frequent need for repetition Yes No
6. Inability to follow sequential instructions Yes No

Has your child received any auditory training? Yes No

If so, which program? _____

Bone conduction performed? Yes No

The Level of Energy

The ear acts as a dynamo, providing us with the energy we need to survive and lead fulfilling lives.

1. Tiredness at the end of the day Yes No
2. Hyperactivity Yes No
3. Tendency towards depression Yes No

Expressive Listening

This is the listening that is directed within. We use it to control our voice when we speak and sing.

1.	Flat and monotonous voice	Yes	No
2.	Hesitant speech	Yes	No
3.	Weak vocabulary	Yes	No
4.	Poor sentence structure	Yes	No
5.	Inability to sing in tune	Yes	No
6.	Confusion or reversal of letters	Yes	No
7.	Poor reading comprehension	Yes	No
8.	Poor reading aloud	Yes	No
9.	Poor spelling	Yes	No

Behavioral and Social Adjustment

A listening difficulty is often related to these:

1.	Low tolerance for frustration	Yes	No
2.	Poor self image	Yes	No
3.	Difficulty making friends	Yes	No
4.	Tendency to withdraw, avoid others	Yes	No
5.	Low motivation, no interest in school work	Yes	No
6.	Immaturity	Yes	No
7.	Irritability	Yes	No
8.	Shyness	Yes	No

List your main concerns regarding your child's development:

_____

_____

_____

_____

Date Questionnaire is completed: _____