Date _____

CHILDREN'S QUESTIONNAIRE

Name of child _____ Date of birth _____

Address _____

City _____ State _____ Zip _____

Parent/Guardian: _____

Tel No _____ Mobile No _____ Email _____

What is your primary concern?:

_____

_____

Is your child currently taking any prescribed medication? Please specify (type/length of time):

_____

_____

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

_____

_____

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

_____

_____

Has your child experienced any injuries in the past (falls, concussions)? If so, when?

_____

_____

The INPP Questionnaire

Devised by Blythe and McGlown. © 1979, 1998. Amended Godddard Blythe 2006.

Part 1 - Neurological

Historical Infancy

What are the primary presenting symptoms?

_____

_____

Questions Regarding Pregnancy and Childhood: Check all applicable

1. Is there any history of learning difficulties in either parent or their families? _____
2. Was your child conceived as a result of IVF? _____
3. When you were pregnant, did you have any medical problems? _____

   e.g. High blood pressure, excessive vomiting, threatened miscarriage, severe viral infection, severe emotional stress, please state:

   _____

   a. Did you smoke during pregnancy? _____

   b. Did you drink alcohol during pregnancy? _____

   c. Did you have a bad viral infection in the first 13 weeks of your pregnancy? _____

   d. Were you under severe emotional stress at any time, but particularly in the first 12 weeks of your pregnancy? _____

4. Was your child born approximately at term, early for term or late for term? _____

   If yes, please give details _____

5. Was the birth process unusual or difficult in any way (vacuum, forceps, prolonged)? _____

   If yes, please give details _____

6. Was your child born via C-section? _____

   If yes, please give details _____

7. When your child was born, was he/she small for term? _____

Please give birth weight, if known _____

8. When he/she was born, was there anything unusual about him/her? _____

i.e. skull distortions, bruising, definitely blue, heavily jaundiced,

covered with a calcium-type coating or require intensive care.

If yes, please give details _____

_____

_____

9. In the first 13 weeks of your child's life, did he/she have difficulty in sucking,

feeding problems, keeping food down or colic? _____

a) Was your child breast fed? (Y) (N)

i) If not why? _____

b) How long was your child breast fed for? _____

10. In the first 6 months of your child's life, was he/she a very still baby,

so still that at times you checked breathing? _____

11. Between 6 months and 18 months, was your child very active and demanding,

requiring minimal sleep accompanied by continual screaming? _____

12. When your child was old enough to sit up and stand up in the crib, did he/she

develop a violent rocking motion, or bang his/her head? _____

13. Did your child reveal any movements/postures that were one sided (head rotation/tilt) _____

If so, describe: _____

14. Was your child early (before 10 months) or late (later than 16 months)

at learning to walk? _____

15. Did he/she go through the motor developmental stage of commando crawling

on his/her tummy? _____

16. Did he/she go through the motor developmental stage of crawling on hands and knees _____

or was your child a bottom shuffler, have a unique crawl or simply one day stood up

and walked? If so, describe: _____

_____

17. Was your child late at learning to talk? (2 - 3 word phrases by 2 years) _____

18. In the first 18 months of life, did your child experience any illness involving high temperatures and/or convulsions? _____

If yes, please give details: _____

19. Was there any sign of infant eczema or asthma? _____

a) Was there any sign of other allergic responses? _____

20. Was there adverse reaction to any of the childhood inoculations? _____

21. Did your child have difficulty learning to dress him/herself? _____

22. Did your child have any behavioral changes after any illness? _____

23. Did your child suck his/her thumb through to 5 years or more? _____

If so, which thumb? _____

24. Did your child wet the bed, albeit occasionally, above the age of 5 years? _____

25. Does your child suffer from travel sickness? _____

SCHOOLING

26. In the first 2 years of formal school did he/she have problems learning to read? _____

27. In the first 2 years of formal schooling did he/she have problems learning to write? _____

28. Did he/she have problems learning to do 'joined up' or cursive writing? _____

29. Did he/she have difficulty learning to tell the time from a traditional clock face as opposed to a digital clock? _____

30. Did he/she have difficulty learning to ride a two-wheeled bicycle (w/o training wheels)? _____

31. Did he/she suffer numerous ear infections, chest issues or suffer from sinus problems? _____

32. Did/does your child have difficulty in catching a ball, i.e. eye-hand coordination concerns? _____

33. Is your child one who cannot sit still, i.e. has 'ants-in-the-pants' and is continually being criticized by the teachers? _____

34. Does your child make numerous mistakes when copying from a book? _____

35. When your child is writing an essay, does he/she occasionally put letters back to front or leave letters or words out? _____

36. If there is a sudden, unexpected noise or movement, does your child over-react? _____

Please add any specific details/concerns about your child (social/learning/specific behaviors):

SCREENING QUESTIONNAIRE (Sheil)
Part 2 Nutritional

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

Gastrointestinal Problems	Check all that apply
Colic	
Tummy pains or gas	
Unusual bowel patterns	
Recurrent constipation	
Diarrhea	
Skin Problems	**Check all that apply**
Eczema	
Dry patches on face or arms	
Tiny bumps on upper arm or thigh	
Dermatitis	
Other: please note	

Ear, Nose and Throat	Check all that apply
Mouth ulcers	
Bad breath	
Tonsillitis	
Earache	
Sinusitis	
Persistent runny nose	
Snoring	
Mouth breathing	
Hay fever	
Asthma	
Induced by Exercise	
Induced by Infection	
Induced by Dust	
Induced by Mold	
Induced by Animals	
Induced by Food	
Induced by anything else, please note	
Dietary involvement	**Check all that apply**
Does your child suffer from excessive thirst?	
Do his or her symptoms get worse if he/she has more than 2-3 hour interval without eating?	
Are there any particular foods which alter his/her behavior?	
If yes, please note	

Part 3 Auditory (Madaule)

Developmental History

1. Was there a delay in motor development? _____
2. Was there a delay in language development? _____
3. Did your child suffer from recurring ear infections? _____
4. Has your child ever been investigated specifically for hearing difficulties? _____

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 _____
2. Distractibility _____
3. Oversensitive to sounds _____
4. Misinterpretation of questions _____
5. Confusion of similar sounding words, frequent need for repetition _____
6. Inability to follow sequential instructions _____

The Level of Energy

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

Do any of the following apply to your child?

1. Tiredness at the end of the day _____
2. Hyperactivity _____
3. Tendency towards depression _____

Expressive Listening

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

Do any of the following apply to your child?

1. Flat and monotonous voice _____
2. Hesitant speech _____
3. Weak vocabulary _____
4. Poor sentence structure _____
5. Inability to sing in tune _____
6. Confusion or reversal of letters _____
7. Poor reading comprehension _____
8. Poor reading aloud _____
9. Poor spelling _____

Behavioral and Social Adjustment

A listening difficulty may be related to these:

Do any of the following apply to your child?

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

Nutritional Intake

Please fill in the following:

1. What does your child usually **eat** and **drink** on a typical weekday?

Breakfast _____

Morning snack _____

Lunch _____

Afternoon snack _____

Dinner _____

Evening snack _____

Desserts _____

2. How many glasses of water does your child drink per day? _____

3. List the three healthiest foods your child eats in an average week:

_____

4. List the three worst foods your child eats in an average week:

_____

5. Please list any vitamins or supplements that your child is currently taking:

_____

_____

6. Has your child suffered with chronic ear infections or illness in the first 2 years? _____

7. How many times has your child been on antibiotics?

a) First two years? _____

b) Ever? _____

How did you hear of Dr. Kara Paat? Please tick as appropriate:

- ☐ Personal recommendation
- ☐ Internet
- ☐ School
- ☐ Doctor
- ☐ Other Health Professional
- ☐ Media
- ☐ Book
- ☐ Lecture
- ☐ Other - please specify

_____

Parent or Guardian Signature: _____ Date: _____

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