CAREGIVER QUESTIONNAIRE
UNC CHILDREN'S SECTION OF DEVELOPMENT, BEHAVIOR, AND LEARNING

Child's Name: _____ **Today's date**: _____

Preferred Name/Nickname: _____ Child's date of birth: _____

Preferred pronouns (circle): he/him she/her they/them other: _____

Name of Person Completing Form: _____ Relation to child: _____

What are your goals for your child's visit? (Choose all that apply)

☐ Help with their development or learning

☐ Help with their behavior

☐ Testing for a specific condition (choose all that apply):

☐ Autism/autism spectrum ☐ ADHD ☐ Learning disability

Comments:_____

What are your favorite things about your child? (Please describe) _____
_____
_____

At home, how does your child usually behave? (Choose all that apply)

☐ usually behaves well ☐ challenging/needs support

☐ sometimes has trouble ☐ very hard to manage

Comments: _____

Does your child have trouble with? (Choose all that apply)

☐ Following directions ☐ Worrying a lot

☐ Paying attention ☐ Being sad

☐ Not sitting still ☐ Getting stuck on an activity/trouble transitioning

☐ Aggressive behavior (hitting, kicking, etc.) ☐ Sensory input (textures, loud noises, etc.)

Comments: _____

Appetite/Eating

☐ Usually eats well ☐ Eats too little

☐ Very choosy about what they eat ☐ Eats too much

Comments: _____

Sleep

☐ usually sleeps well ☐ is a restless sleeper

☐ has trouble falling asleep ☐ snores

☐ wakes up overnight ☐ is tired during the day

Comments: _____

Birth History

Did any of the following happen during the pregnancy? Please check all that apply:

☐ high blood pressure ☐ diabetes ☐ preterm labor ☐ exposure to tobacco smoke

☐ exposure to alcohol or drugs ☐ use of medications ☐ significant stress

Comments: _____

Birth weight: _____ lbs _____ oz Delivery type: (check one) ☐ Vaginal ☐C-section

Was your child: Born on time? (37-40wks) ☐ Yes ☐No

If no, please explain: _____

In the NICU after birth? ☐No ☐Yes If yes, for how long? _____

Early Development

At what age did your child: (please complete)

say their first word _____ (months / years) ☐ not sure ☐ not yet

put two words together _____ (months / years) ☐ not sure ☐ not yet

respond to their name _____ (months / years) ☐ not sure ☐ not yet

start walking _____ (months / years) ☐ not sure ☐ not yet

Medical History

Does your child have any medical conditions? ☐No ☐Yes If yes, please explain _____

Medications/treatments: _____

Past hospitalizations or surgeries? ☐No ☐Yes If yes, please explain: _____

Does/did your child:

Wear glasses? ☐No ☐Yes

Pass a hearing exam ☐No ☐Yes

Have a history of ear infections? ☐No ☐Yes

See other medical specialists? ☐No ☐Yes If yes, please explain: _____

_____

Have upcoming medical tests or procedures? ☐No ☐Yes If yes, please explain:

_____

Family Information

Who lives at home with your child? (e.g., mother, father, brother/sister, grandmother, etc.) _____

_____

Do any of these conditions run in the family? (check all that apply)

☐ Learning problems
☐ ADHD
☐ Anxiety or Obsessive Compulsive Disorder
☐ Depression
☐ Bipolar disorder/manic depression
☐ Autism spectrum disorder
☐ Schizophrenia
☐ Alcohol/substance use
☐ Trouble with the law
☐ Heart problems
☐ Other. Please explain: _____

School Information (Please answer or check where appropriate)

At what age did your child start childcare/school? _____

Name of current childcare/school: _____ Grade: _____

Does your child's teacher have concerns about your child's progress or behavior? ☐ No ☐ Yes

If yes, please explain: _____

Has your child ever repeated a grade? ☐ No ☐ Yes Explain: _____

Does your child have supports through the school system? ☐ No ☐ Yes If yes, please choose below:

☐ IEP

☐ 504 Plan

☐ Tiered classroom intervention

☐ Tutoring

☐ Other. Please explain: _____

Does your child receive any of the following? ☐ No ☐ Yes. If yes, please choose below:

At school

☐ Speech/language therapy (ST)

☐ Physical therapy (PT)

☐ Occupational therapy (OT)

☐ Counseling

☐ Other: _____

Outside of school

☐ Speech/language therapy (ST)

☐ Physical therapy (PT)

☐ Occupational Therapy (OT)

☐ Counseling

☐ Other: _____

Previous testing

Has your child had testing at school or by private therapists or clinicians to address concerns with their learning, development, language, behavior or social functioning? ☐ No ☐ Yes

If yes, please send to us at UNCDBL@med.unc.edu.

Thank you for taking the time to complete this information. Please send it to us at UNCDBL@med.unc.edu.

We look forward to meeting with you!