RICKS CENTER FOR GIFTED CHILDREN
EARLY CHILDHOOD PROGRAM
Developmental Information

The following questionnaire is designed to help us understand your child's developmental history. All information received will be kept strictly confidential. Although complete information on each child would be appreciated, we understand that some parents may choose not to answer or be unable to answer certain questions. Please refer to baby books, old calendars or consult your family doctor for specific developmental information about your child. If you have questions, please contact our Admissions Office at 303-871-3715.

Today's Date _____
Day / Month / Year

Child's Name _____ Gender _____
(First, Middle, Last)

Date of Birth _____ Place of Birth _____
(City, State/Country)

Prenatal History

Age of Mother at birth of child _____ Age of Father at birth of child _____

Birth Order _____ Length of Pregnancy _____

Pregnancy Normal: Yes _____ No _____

If no, please explain _____

Perinatal History

Unusual exposure to
- Radiation ☐ Yes ☐ No
- Medication ☐ Yes ☐ No
- Drugs ☐ Yes ☐ No
- Alcohol ☐ Yes ☐ No
- Cigarettes ☐ Yes ☐ No

Any problems during delivery: ☐ Yes ☐ No

If yes, please explain _____

APGAR Score: one minute _____ five minutes _____
(Scale of 1-10 based on color, breathing, heart rate, reflex, muscle tone)

Other assessment scores _____
(e.g. Denver Diagnostic Screening Test (DDST) or Pediatric Development Questionnaire (PDQ))

Birth Weight _____ Length _____

Healthy at Birth? Yes _____ No _____

If no, please explain _____

Early Developmental History
(Please indicate achievement age in years and months.)

Sat Alone _____	Rode Tricycle _____	First tooth _____
Toilet Trained _____	Toddled _____	Wrote first word _____
Crawled _____	Rode Bicycle _____	First word _____
Scribbled _____	Walked Easily _____	Learned to read _____
First Step _____	Tied shoes alone _____	Complete sentences _____

Additional unusual accomplishments: _____

_____

What unique and/or interesting experiences has your child had? (i.e., special family times, travel, classes, etc.)

_____

_____

Medical History
Hospitalizations: Dates:_____ to____ : (reason) _____

Dates:_____ to____ : (reason)_____

Other pertinent health related information: (e.g. allergies, diabetes, asthma etc.)

_____

_____

Please check the type of care your child had:

Years:	Sitter	Preschool	Home	Daycare	Other	(specify)	Approx. #hrs/wk
0-1	____	____	____	____	____	_____	_____
1-2	____	____	____	____	____	_____	_____
2-3	____	____	____	____	____	_____	_____
3-4	____	____	____	____	____	_____	_____
4-5	____	____	____	____	____	_____	_____

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