SWEDISH PEDIATRICS
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Supplemental Bayley/Developmental Questionnaire

Birth History:	
☐ **Full Term** ☐ **Prematurity at _____ weeks gestation**	
☐ **Single** ☐ **Twin** ☐ **Triplet** ☐ **Other_____**	
Birth Weight:	**Birth Length:**
APGAR Scores: **1 min:_____ 5 min:_____ 10 min:_____**	

Maternal Health During Pregnancy: (check all that apply)

☐ No medical complications
☐ Gestational diabetes
☐ Hypertension
☐ Bed rest
☐ Drug/alcohol exposure
☐ Medications:_____
☐ Other:_____

Labor: (check all that apply)

☐ Spontaneous without complications
☐ Induced
☐ C-section
☐ Forceps and/or suction used
☐ Other:_____

Health of Infant at Birth: (check all that apply)

☐ No issues
☐ Breathing difficulty
☐ Jaundice
☐ Brain bleed
☐ Cardiac issues
☐ Seizures
☐ Gastroschisis
☐ NAS-neonatal abstinence syndrome
☐ Other:_____
☐ Polyhydramnios

Health During Infancy: (check all that apply)

☐ Relatively healthy
☐ Respiratory infections
☐ Reflux
☐ Recurrent ear infections
☐ Feeding difficulties
☐ Inconsolable, frequent crying
☐ Hernia
☐ Other:_____

Gross Motor Milestones: (please indicate **AGE** at which child reached milestone)
Rolled:
Sat:
Crawled:

Stood:
Walk:

Self-Care Skills: (please check yes or no for each statement)		
My child is able to dress him/herself independently (not including clothing fasteners).	☐Yes	☐No
My child is able to feed him/herself independently using a spoon.	☐Yes	☐No
My child is able to feed him/herself independently using a fork.	☐Yes	☐No
My child is able to drink from an open-cup or from a straw.	☐Yes	☐No
My child is able to bathe him/herself independently with only verbal reminders.	☐Yes	☐No
My child is toilet trained. Age potty trained_____	☐Yes	☐No

Sleep: (please check yes or no for each statement)		
My child sleeps independently in his/her own bed/crib.	☐Yes	☐No
My child is able to easily fall asleep at night and for naps.	☐Yes	☐No
My child is able to sleep through the night without waking.	☐Yes	☐No # of times wakes _____
My child snores and/or has a history of sleep apnea.	☐Yes	☐No

Sensory: (please check yes or no for each statement)		
My child dislikes being messy.	☐Yes	☐No
My child is a "picky eater".	☐Yes	☐No
My child seems to constantly be "on the go", having difficulty sitting still.	☐Yes	☐No
My child becomes upset with brushing teeth/hair, bathing, dressing/undressing.	☐Yes	☐No
My child "melts-down" when there is a change in routine, or something unplanned comes up.	☐Yes	☐No
My child becomes easily frustrated and frequently has tantrums.	☐Yes	☐No
My child appears not to "tune-in" to what I say, even though his/her hearing is fine.	☐Yes	☐No

Feeding: (please check yes or no for each statement)		
My child consumes liquids via breast/bottle.	☐Yes	☐No
My child coughs/chokes/gags when eating.	☐Yes	☐No

My child easily transitioned to solid foods.	☐ Yes	☐ No
My child appears to chew his/her food thoroughly.	☐ Yes	☐ No
My child receives nutrition via feeding tube.	☐ Yes	☐ No

Language Comprehension:
Which of the following does your child do most of the time?

□ My child understands environmental cues (ex: asks for food when you are in the kitchen, wants to go out when someone goes to the door)
□ My child understands words that have a lot of meaning to them (bottle, blankie, mama, dad, cracker, etc.)
□ My child understands simple directions (e.g., give me the book)
□ My child can follow two or more directions without any problem (e.g., pick up the book then go get your shoes)

Comments:
_____

_____

Language Expression:

Do you have concerns regarding your language milestones (i.e., cooing, babbling, words, etc.)?
□ Yes □ No

If yes, please explain:

How does your child communicate now? (Check the things your child does most of the time.)

□ Uses behavior: □ Screams □ Yells □ Throws self onto floor □ Pulls away □ Hits
□ Uses gestures: □ Pulls □ Pushes you □ Points □ Shows □ Gives
□ Uses single words: Example_____
How many: □ 1-5 □ 5-10 □ 10-25 □ 25-50 □ 50+

□ Combines words together: Example_____

□ Uses phrases: Example_____

Comments:_____

Articulation
How well can people understand your child's speech? **Choose one.**

□ Most people can understand nearly all that they say
□ Close family members can understand, but others have trouble
□ Most people have trouble understanding
□ N/A

School/Academic Information:	
School currently attending:	
Grade:	Age at which began school:

Does your child currently receive any of the following services: (check all that apply)

☐ Special education ☐ Special testing

☐ In school therapy (speech, occupational, or physical)

Has your child been evaluated for school based therapy services:

☐ Yes **Date of evaluation(s):_____** ☐ No

***IF YES, PLEASE BRING A COPY WITH YOU TO THE EVALUATION.**

Does your child have an IEP/IFSP?

☐ Yes ☐ No

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