Ökumenische Kinder- und Jugendförderung e.V.
Durschstral3e 93 - 78628 Rottweil

Ökumenische Kinder-
und Jugendförderung e.V.

Association for the integration and promotion c
people with and without disabilities

Einganqsfraqeboqen

Name, first name: ______________________________Born: ____________

PREGNANCY

How did the pregnancy go? Were

there any periods of lying-in?

___

___

___

BIRTH

Complications: yes/no - Which? ________________________________Sectio

(cesarean section): yes no Anesthesia/partial anesthesia: o yes

no Week of pregnancy: ____________________

Weight: _________

Size: ____________

APGAR (see U-booklet): ____ _________

Multiple birth: o yes o noNumber __

NEONATAL PERIOD/ HOSPITALIZATION

o without findings

o Hospitalization (Where, When?) ____

o Incubator

o Heat bed

o Jaundice

o Breathing disorder

- o Form of breathing disorder ________________________________
- o Type and duration of ventilation (oxygen? If yes, how long?) __________
- o CPAP ventilation (mask ventilation, tube, tracheal cannula) __________

___

o Drinking behavior (probe) / duration? ________________________________

o Other hospitalizations or abnormalities: ____________________________ ____

DISEASES

o frequent infections (e.g. otitis media, sinusitis...)

o chronic bronchitis

o Operation(s), which and when? ____

o Medication, Which? ____

o Other diseases, Which? ____

FAMILY SITUATION

o Siblings yes/ no (number and age) ___________________________________

o Who is the primary caregiver for the child ?_____

__a Any family burdens: yes no

o Family history (allergies, ADHD...)

____

O Illnesses of the parents (e.g. depression) ___________________________

O Separation of parents ___________________________________

O Traumatic ________________ experiences

DEVELOPMENT OF YOUR CHILD

At what point could her child turn from her back to her stomach or vice versa? ______

In what month could her child:

Crawling _____ MonthSitting __ MonthRunning _Month

How much joy of movement does your child show (1=somewhat, 6=always moves*)*

1 2 3 4 5 6

How does your child react to materials such as sand, mud, and food on their hands?

o great dislike o not noticeable o does not mind at all

Does your child stumble often?

o mucho normal o hardly

How sensitive to pain is your child?

o sehro normal o hardly

Is the child skilled in fine motor skills? (drawing, cutting, stacking, grasping) o dexterous o normal o has problems

Does your child get sick quickly when driving or rocking?' often o normally hardly ever

Can you remember your child's babbling phases and sounds? Phases of babbling ______Month
Loud ______Month

When did your child speak the first word? ______Month
When did your child speak two-word phrases (e.g., "have ball")? ______Month
Is your family multilingual? o no o yes
If yes, what is the native language? ____________________________
Do you notice anything unusual about your child's pronunciation? o noo yes
If so, what? ____
Do you have the impression that your child hears well? Does your child show excessive salivation? Does your child like to talk a lot? c yeso no
o no o yes
o noo yes
Drinking and eating behavior o normalo striking

Does your child respond to and follow through on names, prompts?
o always o most of the time o hardly o never

Does your child go to kindergarten† o no o yes
If yes, since when and in which ones? ________________________________

How would they describe their child's temperament?
otemperamental o balanced oespecially calm
Does your child allow physical contact? o no o yes o a lot
o little Does your child have contact with other children? o no o yesIf yes, what does this contact look like†

____

What special behaviors does your child have?

Is your child brave? o noo yes

Is your child curious and interested? o noo yes

Does he/she show perseverance in play and activities? (e.g., can finish things that have been started?) o no o yes

What are your child's favorite games?

____

Who does your child play with?

____

What special skills, abilities, and preferences does your child have?

____

In which everyday situation is your child already independent?

o Washingo Dressing o Way to the kindergarten

o Other ____

What other leisure activities does your child do?

o Mother-child gymnasticsa Toddler groupo Pekip group a Music school

o Children's gymnastics a O t h e r ______________________________

What measures and surveys have taken place so far?

o Social Pediatric Centera Early interventiona Hearing test o Eye test

o Speech therapyo Occupational therapya Physiotherapy

o Other counseling centers ____________ o O t h e r ______________

Is there any provision of aids (wheelchair, orthoses, glasses, hearing aid...) ?

o yes ü no

If yes, which ones? ______________________________

Why did you register your child with us?/ What are you concerned about?

____

____

____

____

____

Place, date Signature