ADULT SCREENING QUESTIONNAIRE FOR NEURODEVELOPMENTAL DELAY

Name ……..…… Date of Birth …….……..

Address …….…….…….…….……..

……..

Tel No …….. Mobile No …….…….…….

Email …….....

Has a diagnosis been given at any time (ie.. Dyslexia, Dyspraxia, ADHD, ADD)?

If so, please state:

……..

PART 1 – NEUROLOGICAL DEVELOPMENT

Infancy

Please check if known

1. Is there any history of similar difficulties in your parents or their families? ……

2. Were you conceived as a result of IVF? ……

3. When your mother was pregnant with you, did she have any medical problems? ……

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

……..

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a. Did she smoke during pregnancy? ……

b. Did she drink alcohol during pregnancy? ……

c. Did she have a bad viral infection in the first 13 weeks of her pregnancy? ……

d. Was she under severe emotional stress between 25^{th} -27^{th} week of her pregnancy? ……

e. If known, how many ultra-sound scans were performed? ……

4. Were you born approximately at term, early for term or late for term? ……

Please give details ……..

Was the birth process unusual or difficult in any way?

- Induced (please state reason)
- Prolonged Labor
- Precipitate (fast) Labor
- Forceps
- Ventouse
- Cesarean Section (elective or emergency)

If yes, please give details ……

5. When you were born, were you small for term? ……

Please give birth weight, if known ……

6. When you were born, was there anything unusual about you? ……

i.e. the skull distorted, heavy bruising, definitely blue, heavily jaundiced,

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

If yes, please give details……

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7. In the first 13 weeks of your life, did you have difficulty in sucking, feeding or keeping food down?

8. Were you breast fed? ……

How long did breast feeding continue? ……

9. In the first 6 months of your life, were you a very still baby, so still ……

That at times your mother wondered if it was a crib death?

10. Between 6 months and 18 months, were you very active and demanding, ……

Requiring minimal sleep accompanied by continual screaming?

11. When you were old enough to sit up in a stroller and stand up in the crib, did you develop a violent rocking motion, so violent that either the stroller or crib was actually moved? ……

12. Did you become a "head-banger" ie. Bang your head deliberately ……

into solid objects?

13. Did you go through a motor stage of crawling on the stomach, and ……

Creeping on the hands and knees, or were you a "bottom-hopper" or

"roller" who one day stood up?

If yes, please give details ……..

14. Were you a child late at learning to walk? ……

15. Were you a child late at learning to talk? (3 word phrases)

16. In the first 18 months of life, did you experience any illness involving ……

high temperatures and/or convulsions?

If yes, please give details ……

……

17. Was there any sign of infant eczema or asthma? Yes/No

Was there any sign of allergic responses? Yes/No

Was there adverse reaction to childhood vaccinations? Yes/No

18. Did you have difficulty learning to dress? Yes/No

19. Did you suck your thumb through to 5 years or more? Yes/No

If so, which thumb? Right/Left

20. Did you wet the bed, albeit occasionally, above the age of 5 years? Yes/No

21. Did you suffer from motion sickness? Yes/No

School

22. When you went to grade school, in the first 2 years of schooling, Yes/No

did you have problems learning to read?

23. In the first 2 years of formal schooling, did you have problems Yes/No

learning to write?

24. Did you have problems learning to do "joined up" or cursive writing? Yes/No

25. Did you have difficulty learning to tell the time from a traditional clock face as opposed to a digital clock? Yes/No

26. Did you have difficulty learning to ride a two-wheeled bicycle? Yes/No

27. In the first 8 years of your life were there any illness involving very high temperatures, delirium or convulsions (excluding any illness in the first 18 months of life? Yes/No

If yes, please explain what illness you had and how old you were:

Illness ……. Age ……

Illness ……. Age ……

Illness ……. Age ……

28. In the first 8 years of your life, were you the child who continually suffered from colds, chest infections or ear problems? Yes/No

29. Did you have difficulty in catching a ball, i.e. eye-hand coordination problems? Yes/No

When you were older and had to do gymnastics, did you have more trouble than all your classmates in doing things like forward rolls, handstands, climbing a rope, balancing or jumping over a vault horse? Yes/No

30. Did you have difficulty sitting still, i.e. had "ants-in-the-pants" and were continually being criticized by the teachers? Yes/No

31. Did you make numerous mistakes when copying from a book or blackboard? Yes/No

32. When you wrote an essay or news item at school, did you occasionally put letters back to front or miss letters or words out? Yes/No

Present – Adulthood

33. If there is a sudden, unexpected noise or movement, do you over-react? Yes/No

34. Do you have agoraphobia, panic attacks, extreme anxiety? Yes/No

How old were you when these problems started? ……..

What symptoms did you have? ……..

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Is there any one place where your symptoms are worse?

If yes, where or when? …….

…….

37. Do you have feelings that at times you will fall over?

Often ……

Sometimes ……..

Never ……

38. Do you see things moving which you know cannot move,

i.e. buildings, trees, ect?

Often ……

Sometimes ……..

Never ……..

39. Do you ever feel that your eyes will not work properly at

times, i.e. that they do not focus properly, or play tricks on you?

Often ……

Sometimes ……..

Never ……..

40. Do you suffer from feelings of nausea?

Often ……

Sometimes ……..

Never ……...

41. Do you have feelings of dizziness?

Often ……

Sometimes ……..

Never ……...

42. Do you have feelings of dizziness while lying in bed?

Often ……

Sometimes ……..

Never ……

43. Do you feel that you have poor balance? Yes/ No

44. Do you feel your coordination is very bad at times? Yes/No

Part 3

45. Do you, or have you suffered from migraines?

Often ……

Sometimes ……..

Never ……

46. Are you very sensitive to bright lights? Yes/No

(Have you been to a dance club with flashing lights

and does this affect you?)

47. Would you say that you are more sensitive to sound than everyone you know? Yes/No

48. Do you have problems in sorting out which is left and right when giving Yes/No

Directions, or sorting out which is your left and right hand?

49. When you are writing something long and complicated, do you find that after a time you begin to make silly mistakes, such as putting letters in the wrong order, words in the wrong order, or your ability to spell even simple words becomes difficult?

Often ……

Sometimes ……..

Never ……...

50. When you are very, very tired do you find that you know what you want to say, but what you do say actually comes out jumbled up?

Often ……

Sometimes ……..

Never ……..

51. When you are very, very tired do you find that your coordination goes, and you bump into things or become clumsy?

Often ……

Sometimes ……..

Never ……...

Please add any extra information you think may be appropriate:

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