Developmental Screening for Kids 0-8 years old
To be filled by Parent/Primary Care giver

Patient Name: _____ Patient Date of Birth_____Age__
Filler's Name & Relation__ _____ Todays Date _____

1. Please list concerns, if any, about your child's behavior, development, or learning

2. Is your child able to talk or make speech sounds? Do you have any concerns?

Check one: ◯ NO ◯ YES ◯ Slight concern

3. Does your child understand what you say? Do you have any concerns?

Check one: ◯ NO ◯ YES ◯ Slight concern

4. Does your child use his or her hand and fingers to do things? Do you have any concerns?

Check one: ◯ NO ◯ YES ◯ Slight concern

5. Does your child use his arms and legs freely? Do you have any concerns?

Check one: ◯ NO ◯ YES ◯ Slight concern

6. Does your child behavior concern you?

Check one: ◯ NO ◯ YES ◯ Slight concern

7. How does your child get along with others? Do you have any concerns?

Check one: ◯ NO ◯ YES ◯ Slight concern

8. Is the child learning to do things for himself/herself? Do you have any concerns?

Check one: ◯ NO ◯ YES ◯ Slight concern

9. Do you have any concerns about how your child is learning at home/preschool/school?

Check one: ◯ NO ◯ YES ◯ Slight concern

10. Do you have any OTHER concerns?