



**The Institute for Neuro-Physiological Psychology**

**CHILDREN'S QUESTIONNAIRE**

NF

Name of child ..... Date of Birth .....

Address .....

.....Parent/Guardian .....

Tel No ..... Mobile No ..... Email .....

Has a diagnosis been given at any time i.e. Dyslexia, Dyspraxia, ADHD, ADD?  
If so, please state:

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Is your child currently taking any prescribed medication? Please specify:

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What investigations/interventions has your child received in the past?

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What are the presenting symptoms:

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## The INPP Screening Questionnaire

Devised by Blythe and McGlown. © 1979, 1998. Amended Goddard Blythe 2006.

### Part 1 – Neurological

#### Historical Infancy

#### Numbered Questions:

Please delete as appropriate

1. Is there any history of learning difficulties in either parent or their families? Yes/No
2. Was your child conceived as a result of IVF? Yes/No
3. When you were pregnant, did you have any medical problems?  
e.g. High blood pressure, excessive vomiting, threatened miscarriage,  
severe viral infection, severe emotional stress, please state .....
- a) Did you smoke during pregnancy? Yes/No
- b) Did you drink alcohol during pregnancy? Yes/No
- c) Did you have a bad viral infection in the first 13 weeks of your pregnancy? Yes/No
- d) Were you under severe emotional stress at any time, but particularly in the first 12 weeks of your pregnancy? Yes/No
4. Was your child born approximately at term, early for term or late for term? Yes/No  
Please give details .....
5. Was the birth process unusual or difficult in any way? Yes/No  
If yes, please give details .....
6. When your child was born, was he/she small for term? Yes/No  
Please give birth weight, if known .....
7. When he/she was born, was there anything unusual about him/her?  
i.e. the skull distorted, heavy bruising, definitely blue, heavily jaundiced, covered with a calcium-type coating or require intensive care. Yes/No  
If yes, please give details .....
8. In the first 13 weeks of your child's life, did he/she have difficulty in sucking, feeding problems, keeping food down or colic? Yes/No  
a) Was your child breast fed? Yes/No  
b) How long was your child breast fed for? .....

9. In the first 6 months of your child's life, was he/she a very still baby, so still that at times you wondered if it was a cot death? Yes/No
10. Between 6 months and 18 months, was your child very active and demanding, requiring minimal sleep accompanied by continual screaming? Yes/No
11. When your child was old enough to sit up in the pram and stand up in the cot, did he/she develop a violent rocking motion, so violent that either the pram or cot was actually moved? Yes/No
12. Did your child become a 'head-banger' i.e. bang his/her head deliberately into solid objects? Yes/No
13. Was your child early (before 10 months) or late (later than 16 months) at learning to walk? Yes/No
14. Did he/she go through the motor developmental stage of crawling on his/her tummy? (commando crawling) Yes/No
15. Did he/she go through the motor development stage of creeping on hands and knees? Yes/No  
Or was your child a bottom shuffler, or simply one day stood up and walked? Yes/No
16. Was your child late at learning to talk? (2 – 3 word phrases by 2 years) Yes/No
17. In the first 18 months of life, did your child experience any illness involving high temperatures and/or convulsions? Yes/No  
If yes, please give details .....
18. Was there any sign of infant eczema or asthma? Yes/No  
a) Was there any sign of other allergic responses? Yes/No
19. Was there adverse reaction to any of the childhood inoculations? Yes/No
20. Did your child have difficulty learning to dress him/herself? Yes/No
21. Did you child suck his/her thumb through to 5 years or more? Yes/No  
If so, which thumb? Right/Left
22. Did your child wet the bed, albeit occasionally, above the age of 5 years? Yes/No
23. Does your child suffer from travel sickness? Yes/No
24. When your child went to the first formal school, i.e. infant school, in the first 2 years of schooling, did he/she have problems learning to read? Yes/No

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|--|--------|
| 25. In the first 2 years of formal schooling did he/she have problems learning to write?   | Yes/No |
| Did he/she have problems learning to do 'joined up' or cursive writing?  | Yes/No |
| 26. Did he/she have difficulty learning to tell the time from a traditional clock face as opposed to a digital clock?                              | Yes/No |
| 27. Did he/she have difficulty learning to ride a two-wheeled bicycle?   | Yes/No |
| 28. Was or is he/she an Ear, Nose and Throat (ENT) child, i.e. suffer numerous ear infections, is a 'chesty' child or suffers from sinus problems? | Yes/No |
| 29. Did/does your child have difficulty in catching a ball, i.e. eye-hand coordination problems?   | Yes/No |
| 30. Is your child one who cannot sit still, i.e. has 'ants-in-the-pants' and is continually being criticized by the teachers?                      | Yes/No |
| 31. Does your child make numerous mistakes when copying from a book?   | Yes/No |
| 32. When your child is writing an essay or news item at school, does he/she occasionally put letters back to front or miss letters or words out?   | Yes/No |
| 33. If there is a sudden, unexpected noise or movement, does your child over-react?  | Yes    |

Please add any extra information if necessary:

**SCREENING QUESTIONNAIRE** (Sheil)

**Part 2 – Nutritional**

Has your child suffered from any of the following at regular intervals?

1. **Gastro intestinal problems** Please tick as appropriate

- Colic
- Tummy pains or wind
- Unusual bowel patterns
- Recurrent constipation
- Diarrhoea

2. **Skin problems**

- Eczema
- Dry patches on face or arms
- Nutmeg grater skin on upper arm or thigh (little tiny bumps)
- Dermatitis
- Anything else, please specify

3. **Ear, Nose and Throat problems**

- Mouth ulcers
- Bad breath
- Tonsillitis
- Earache
- Sinusitis
- Persistent runny nose
- Snoring
- Mouth breathing
- Hay fever

4. **Asthma**

- Induced by:
- Exercise
- Infection
- Dust
- Mould
- Animals
- Food
- Anything else, please specify .....

5. Does your child suffer from excessive thirst? Yes/No

Do his/her symptoms get worse if he/she has more than a 2-3 hour interval without eating? Yes/No

Are there any particular foods which alter his/her behaviour? Yes/No

If yes, please specify .....

### Part 3 – Auditory (Madaule)

#### **Developmental History**

Please tick as appropriate

1. Was there a delay in motor development?
2. Was there a delay in language development?
3. Did your child suffer from recurring ear infections?
4. Has your child ever been investigated specifically for hearing difficulties

#### **Receptive Listening**

This is the listening that is directed outward. It keeps us attuned to the world around us

Do any of the following apply to your child?

1. Short attention span
2. Distractibility
3. Oversensitive to sounds
4. Misinterpretation of questions
5. Confusion of similar sounding words, frequent need for repetition
6. Inability to follow sequential instructions

#### **The Level of Energy**

The ear acts as a dynamo, providing us with the energy we need to survive and lead fulfilling lives.

1. Tiredness at the end of the day
2. Hyperactivity
3. Tendency towards depression

#### **Expressive Listening**

This is the listening that is directed within. We use it to control our voice when we speak and sing

1. Flat and monotonous voice
2. Hesitant speech
3. Weak vocabulary
4. Poor sentence structure
5. Inability to sing in tune
6. Confusion or reversal of letters
7. Poor reading comprehension
8. Poor reading aloud
9. Poor spelling

#### **Behavioural and Social Adjustment**

A listening difficulty is often related to these:

1. Low tolerance for frustration

- 2. Poor self image
- 3. Difficulty making friends
- 4. Tendency to withdraw, avoid others
- 5. Low motivation, no interest in school work
- 6. Immaturity
- 7. Irritability
- 8. Shyness

*How did you hear of INPP?*

Please tick as appropriate:

- Personal recommendation
- Internet
- School
- Doctor
- Other Health Professional
- Media
- Book
- Lecture
- Other – please specify

Date questionnaire completed .....