Notes on filling out this form:
Please fill in or mark with a cross ☒
Answering all or just individual questions is voluntary!

Child's family name	Child's first name	Born on	Nationality	Number of siblings

Native language (mother)	Native language (father)	Number of adults in the household	Has been attending crèche/ daycare/kindergarten for ☐ years

Name and address of parent or legal guardian

Family name(s)………………………………First name(s)……………………………… Postcode/town………………………….

Street……………………………………………………………………Tel. no…………………………………………………

Pregnancy and birth

Birth weight: I__I__I__I__I *grams* Completed pregnancy weeks: I__I__I *PWs* ☐ Multiple birth

Development

Has any delayed development ever been determined in your child?	☐ Yes	☐ No
Unassisted walking by 18 months	☐ Yes	☐ No
First words (such as *mum*, *dad*, *car*) by 18 months	☐ Yes	☐ No
Speech disorder during development	☐ Yes	☐ No
Child grows up multilingual	☐ Yes	☐ No

Which languages do you speak at home?

☐ German ☐ Other language(s) (which): ____________________

In contact with the German language ☐ from birth ☐ not from birth

If not in contact with the German language from birth, from which age? I___I Years I___I___I months

Is your child ☐ right-handed ☐ left-handed ☐ still undecided

Does your child have or has your child had one of the following illnesses or health impairments?

Has your child ever been examined by an eye specialist? ☐ No ☐ Yes

If *Yes*, please answer the following questions:

▶ Were drops used for pupil dilation? ☐ No ☐ Yes

▶ Was a visual impairment determined? ☐ No ☐ Yes

↳ If *Yes*, what treatment was performed?

▶ Glasses ☐ No ☐ Yes

▶ Eye patch/training ☐ No ☐ Yes

▶ Strabismus operation ☐ No ☐ Yes ☐ Planned

Serious congenital hearing disorder ☐ No ☐ Yes

If *Yes*, please answer the following questions:

Congenital hearing disorder	☐ Left ear	☐ Right ear	☐ Both sides
Wears hearing aid	☐ Left ear	☐ Right ear	☐ Both sides
Wears cochlear implant	☐ Left ear	☐ Right ear	☐ Both sides

Please turn over!

Metabolic or hormone disorders: ☐ No ☐ Yes

If Yes, which? ☐ MCAD deficiency ☐ Hypothyroidism (congenital) ☐ PKU ☐ CAH
☐ Cystic fibrosis ☐ Diabetes mellitus (type 1) ☐ Diabetes mellitus (type 2)

☐ Other: ……………………………………………………….

Age at diagnosis: I___I I___I___I
Years *Months*

Other chronic illnesses: ☐ No ☐ Yes *(which?):* ……………………..……………………..

Severe handicap: ☐ No ☐ Yes *(which?):* …………………..………..………………..

Must take medication regularly: ☐ No ☐ Yes *(which?):* …………………………..…………..

Are you aware of illnesses your child may have that require specific procedures in emergency situations (e.g., allergies, epilepsy, etc.)? ☐ No ☐ Yes

If Yes, which? ……………………………………………………………………………………………………

Pediatrician/family doctor:
……………………………………………………………………………………...

……….………………

Has your child ever had any of the following assistance measures or treatments?

Participation in German prep classes	☐ No	☐ Yes		☐ Planned
Speech therapy (logopedics)	☐ No	☐ Completed	☐ Ongoing	☐ Planned
Physiotherapy	☐ No	☐ Completed	☐ Ongoing	☐ Planned
Remedial education	☐ No	☐ Completed	☐ Ongoing	☐ Planned
Orthopaedagogy	☐ No	☐ Completed	☐ Ongoing	☐ Planned
Ergotherapy	☐ No	☐ Completed	☐ Ongoing	☐ Planned

How often does your child see the dentist?
☐ At least once a year for check-up
☐ Less than once a year for check-up
☐ Only when they have a complaint
☐ My child has never been to the dentist

Would you say that, on the whole, your child has difficulties in one or more of the following areas: Voice (despondent, anxious, wavering, explosive), concentration (cannot sit still for long, doesn't listen consistently when being read to), behavior, interaction with others?
☐ No☐ Yes

Are there any of the following in the family (parents, siblings)

► Reading-writing difficulty (dyslexia)?	☐ No	☐ Yes
► Difficulty calculating (dyscalculia)	☐ No	☐ Yes
►Strabismus	☐ No	☐ Yes
► Severe longsightedness (>3dpt), astigmatism >3dpt, shortsightedness >10dpt	☐ No	☐ Yes

Date of completion: ………………………………………