# The Fife Neurodevelopmental Questionnaire

# F-NDQ

Child form (ages 1-18)

Version 2

| | | | |
|---|---|---|---|
| Date of Birth | | CHI Number (if known) | |
| Child Name | | Date completed | |
| Child Address | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Services this child is or has been involved with | Community Paediatrics | | Child and Adolescent Mental Health Services | | Speech and Language Therapy | |
| | Child Development Centre | | Occupational Therapy, Physiotherapy, or Dietetics | | Learning Disability Services | |
| | Educational Psychology | | Social Work | | Other: Please specify below | |
| | | | | | | |

| | | | |
|---|---|---|---|
| Name of person completing | | Relationship to child | |
| Address (if different) | | | |
| Contact number | | | |

| **For clinic use** Details of professional issuing and reviewing F-NDQ | | | |
|---|---|---|---|
| Name: | | Profession: | |

# Instructions

This form will ask you questions about how your child has grown and changed over time. It will give you a chance to tell us about any worries or concerns you have about your child.

This form will give us essential information we need to assess and support your child. This form is very long and can take some time to complete, but the information you give us is really important. We will also put this completed form on your child's permanent electronic health record, so other health professionals working with your child can see it, and won't need to ask you the same questions again. Many professionals working with your child now, and in the future, will use this to learn about your child, and find out essential information about them, so please complete it to the best of your ability, and ask for help if you need it. You should only need to complete this once for your child, although we might ask you to update it in the future.

Some questions might be challenging or emotional to answer. The people reading this know that parenting is difficult, and that everyone copes in different ways. You can leave any questions you are worried about blank, and discuss these in person with the person who gave you this form.

### Top tips for completing this form

- Read the form through before completing, so you know what you're going to be asked.
- Complete the form with a partner, grandparents, or friend, so you can discuss your answers.
- If you find it helpful, dig out your child's 'red book', home videos, and look through photo albums and social media to remind yourself what your child was like when younger.
- Think about what your child is like at school, with friends, or out and about, not just at home.
- This form can take several hours to complete. Don't try to do it all at once. Take your time, and do it over several sessions.
- Please try and answer the questions as honestly and fully as possible. Information that is not accurate or missing can make it harder for us to work out how to help your child.
- All parents have things they can't remember - just answer what you can.
    - If you don't know, just write "**don't know**" or "**DK**" for short.
    - If you aren't sure, add a **question mark** (**?**) to show it is a best guess (e.g. "5 months?").
    - Some questions may not apply to your child. This is ok, just put "**not applicable**" or "**N/A**"
- If a child is adopted or in care, some information about their biological family, pregnancy and early history may not be known, or can't be shared. Don't worry if there are some questions that you can't answer, just provide what information you can.
- If you have difficulty completing this form, you can ask someone who knows your child well, such as a relative, teacher or health professional to help you fill it in.

# Section 1: Family Concerns and Priorities

| When did you first have concerns about your child? What were they? |
| --- |
| |
| **How have your concerns changed over time? What are the main concerns about your child right now?** |
| |
| **What help and advice have you and your child already had for these concerns/difficulties? What (if anything) has helped?** |
| |
| **What concerns prompted you to ask for this assessment/service? What would you and your child like to gain from this assessment or service?** |
| |

# Section 2: Family History

Please tell us about all parental figures in your child's life, past and present. Even if your child was removed at birth, please include as much information about biological parents as you are able to.

| Type of parent relationship: | **Biological / Adoptive / Step / Foster / Kinship / Other (specify below)** | **Biological / Adoptive / Step / Foster / Kinship / Other (specify below)** |
|---|---|---|
| **Name**: | | |
| **Date of Birth**: | | |
| **Main occupations** (past/present): | | |
| **Any physical or mental health issues?**<br><br>**Any medication?** | | |
| **How long was/has the child been in their care**? | | |
| **Other information**: e.g kinship carer's relationship to child, has no contact, etc | | |

| Type of parent relationship: | **Biological / Adoptive / Step / Foster / Kinship / Other (specify below)** | **Biological / Adoptive / Step / Foster / Kinship / Other (specify below)** |
|---|---|---|
| **Name**: | | |
| **Date of Birth**: | | |
| **Main occupations** (past/present): | | |
| **Any physical or mental health issues?**<br><br>**Any medication?** | | |
| **How long was/has the child been in their care**? | | |
| **Other information**: e.g kinship carer's relationship to child, has no contact, etc | | |

## Brothers and sisters

| Relationship (circle): | Full / Half / Step / Adoptive | Full / Half / Step / Adoptive | Full / Half / Step / Adoptive |
|---|---|---|---|
| Name: | | | |
| Date of Birth: | | | |
| School/Occupation: | | | |
| Any physical or mental health issues?<br><br>Any medication? | | | |
| **Relationship (circle):** | **Full / Half / Step / Adoptive** | **Full / Half / Step / Adoptive** | **Full / Half / Step / Adoptive** |
| Name: | | | |
| Date of Birth: | | | |
| School/Occupation: | | | |
| Any physical or mental health issues?<br><br>Any medication? | | | |
| **Relationship (circle):** | **Full / Half / Step / Adoptive** | **Full / Half / Step / Adoptive** | **Full / Half / Step / Adoptive** |
| Name: | | | |
| Date of Birth: | | | |
| School/Occupation: | | | |
| Any physical or mental health issues?<br><br>Any medication? | | | |

## Extended family

| Has anyone in your child's birth family (including cousins, grandparents, etc) ever been suspected to have or been diagnosed with: | | |
|---|---|---|
| **Attention Deficit Hyperactivity Disorder (ADHD)?** | Yes/No | If yes, please tell us who, and what they were suspected to have/been diagnosed with: |
| **Autism** (Including Asperger's Syndrome) | Yes/No | |
| **Co-ordination difficulties?** (e.g Dyspraxia or Developmental Coordination Disorder) | Yes/No | |
| **Learning Difficulties?** (e.g Dyslexia or Dyscalculia) | Yes/No | |
| **Learning Disability?** | Yes/No | |
| **Speech and Language Difficulties?** | Yes/No | |
| **Anything else?** | Yes/No | |
| Is there any history of **heart conditions or sudden unexpected deaths** in the child's biological family**?** | Yes/No | If yes, please tell us who, and provide details |
| Is there any history of **addiction** in the child's family? | Yes/No | |

| **Who lives at home full time?** | | |
|---|---|---|
| | | |
| **Are there any regular visitors or people who stayover within the family home?**<br><br>(e.g sibling living between parents, new partner visiting, etc) | Yes/No | If yes, please tell us about these people, their relationship to your child, and how often they visit: |
| **Does your child regularly visit or stay somewhere else overnight?**<br><br>(Visiting other parent on weekends, visiting grandparents, etc) | Yes/No | If yes, please tell us where they go, how often, and their relationship to the carer: |

# Section 3: Pregnancy and Birth

Pregnancy is a very important time for the child, mum, and the whole family. It would be helpful for us to understand birth mother's life circumstances before, during and after this pregnancy. For children who are adopted, or looked after, we appreciate you may have been given only limited information, if any. Please include any information you can share.

| **Please tell us about birth mother's life circumstances before she became pregnant, including:** | | |
|---|---|---|
| Was birth mother under a lot of **stress** in the months before pregnancy? | Yes/No | If yes, or if any other relevant information, please give details: |
| Was birth mother taking any **medication** in the months before pregnancy? | Yes/No | |
| Did birth mother have any **physical or mental health difficulties** in the months before pregnancy? | Yes/No | |
| Did birth mother **smoke or vape** in the months before becoming pregnant? If so how much? | Yes/No | |
| Did birth mother **drink alcohol** in the months before becoming pregnant? If so, what did she drink, how much, and how often? | Yes/No | |
| Did birth mother use any **non-prescription drugs** in the months before becoming pregnant? If so, what did she take, how much, and how often? | Yes/No | |
| **Did birth parents have any difficulties conceiving?** Such as IVF, or recurrent miscarriages | Yes/No | If yes, please give details: |
| **Was the pregnancy planned or a surprise?** | Planned/Surprise | If planned, did mum make any lifestyle changes while trying to get pregnant (taking folic acid, avoiding alcohol, etc)? |

| | |
|---|---|
| A typical pregnancy is 40 weeks, starting from the first day of mum's last period.<br><br>**How many weeks pregnant was birth mother when she realised she was pregnant?** | |
| **What were birth mother's thoughts and feelings about being pregnant? Did this change over time?**<br><br>Was she excited? Nervous? Worried? Relieved? Upset? Scared? | |
| **What (if any) support did birth mother receive during pregnancy?**<br><br>E.g, antenatal classes, ultrasound scans, midwife appointments, support from friends and family. | |

Often, pregnancy leads to a lot of changes to a family's lifestyle, birth mother's in particular. Some of these changes can be hard to do, such as making room at home for a new baby, changing diet, or avoiding alcohol. **What, if any, lifestyle changes did birth mother make (or try to make) after finding out that she was pregnant?**

| | | |
|---|---|---|
| Did birth mother have **any stressful events during pregnancy**? | Yes/No | If yes, please give details |
| Once birth mother knew she was pregnant, **did her medication change**? How? | Yes/No | |
| Once birth mother knew she was pregnant, **did her smoking or vaping habits change?** How? | Yes/No | |
| Once birth mother knew she was pregnant, **did her use of alcohol change?** How? | Yes/No | |
| Once birth mother knew she was pregnant, **did her use of non-prescription drugs change?** How? | Yes/No | |

| During pregnancy, were there any problems or concerns relating to: | | |
|---|---|---|
| Results of scans/neonatal screening? | Yes/No | If yes, please give details |
| Bleeding, trauma, etc? | Yes/No | |
| Blood pressure problems? | Yes/No | |
| Infections? | Yes/No | |
| Any concerns leading to increased monitoring, extra scans, etc | Yes/No | |
| Anything else? | Yes/No | |

| Birth | | |
|---|---|---|
| **Was your child born at the expected time?**<br><br>(full term is considered to be 37-40 weeks, but many babies are later and some may be earlier) | Yes/No | If no, how many weeks were they born at? |
| **What was your child's birth weight?** | | |
| **Were there problems <u>during labour</u> that required intervention for birth mother or child?**<br><br>e.g loss of blood, foetal distress/low heart rate, emergency caesarean section or forceps delivery, etc | Yes/No | If yes, please give details, including how long they were in hospital for. |
| **Did your child require any special care after birth?**<br><br>e.g oxygen, light therapy, incubator, IV antibiotics, etc | Yes/No | |
| **Did birth mother require any special care after birth?**<br><br>e.g blood transfusion, surgery, etc | Yes/No | |
| **What were mum's thoughts and feelings about this child after birth?** Was it easy to bond? Did she have worries about the baby? Did they feel 'different'? | | |

| First year | | |
|---|---|---|
| **Did mum suffer from significant mood or mental health difficulties in the months after giving birth?**<br><br>e.g post-natal depression, or separation anxiety? | Yes/No | If yes, please give details |
| **Please tell us about your child's feeding as an infant** | Breast fed from: to:<br><br>Bottle fed from: to:<br><br>Weaning to solids started: | |
| **Did your child have any problems feeding as an infant?**<br><br>When did they start/end? What caused them? Did you get any help for this? | Yes/No | If yes, please give details |
| **Please tell us about your child's sleep during the first year of life**<br><br>Did they have a regular sleep pattern? How long did they sleep for? Did they have problems sleeping? | | |
| **What was your child like *as a person* in the first year of life?**<br><br>Were they smiley? Clingy? Cried a lot? Never pleased? Always hungry? Playful? Overly passive? | | |
| **Did mum or child have any difficulties bonding in the first year of life?** | Yes/No | If yes, please tell us about these difficulties |

# Section 4: Medical History

| | | |
|---|---|---|
| **Has your child ever been <u>diagnosed</u> with any condition not already discussed?** | Yes/No | What conditions? Were these investigated? What was the result? |
| **Has your child ever been <u>suspected</u> to have any condition not already discussed?** | Yes/No | |
| **Have there ever been any concerns about your child's hearing or vision?** | Yes/No | If yes, please tell us about your child's hearing and vision |
| **Has your child ever had their hearing or vision checked/ tested?** | Yes/No | |
| **Does your child require any vision or hearing aids?**<br><br>E.g glasses, hearing aids, etc | Yes/No | |
| **Does your child suffer from constipation, or other difficulties with pooing and/or peeing?** | Yes/No | If yes, please give details |

| | | |
|---|---|---|
| **Now, or in the past, has your child been on any regular medication?** | Yes/No | If yes, please give names, dates and dosage |
| **Are your child's immunisations complete?** | Yes/No | If no, what have they not had? |
| **Has your child had any reactions to immunisations?** | Yes/No | If yes, please specify symptoms experienced and how they are managed |
| **Does your child have any allergies?** | Yes/No | |
| **Has your child had any significant head injuries**?<br><br>i.e that caused nausea, drowsiness, headaches, blurred vision, confusion, loss of consciousness, or required a visit to A+E? | Yes/No | If yes, please give details, including age |
| **Has your child had any infectious diseases**<br>e.g chicken pox, measles etc? | Yes/No | |
| **Has your child had any serious illnesses, operations, hospitalisations, or medical complaints not already discussed?** | Yes/No | |

# Section 5: Educational History

| | Name of school(s) | Age attended | Did you or your child's teachers have any comments or concerns about your child at this time? |
|---|---|---|---|
| **Nursery/ Preschool** | | | |
| **Primary School** | | | |
| **Secondary school** | | | |
| **Other e.g childminder, home schooled, etc** | | | |

| **Education concerns** | | |
|---|---|---|
| **If you know, please tell us your child's current curriculum level, grades, or exam results** | | |
| **Do <u>you</u> have any concerns about your child's academic progress at school?** Do you think your child is having difficulties with their school work? | Yes/No | If yes, please tell us about these concerns or difficulties: |
| **Have <u>your child's teachers</u> mentioned any concerns about your child's academic progress at school?**<br><br>Are teachers saying your child is having difficulties with their school work? | Yes/No | |

| | | |
|---|---|---|
| **Does your child receive any extra support at school?**<br><br>e.g 'time out' card, pupil support assistant, extra literacy or numeracy classes, etc | Yes/No | If yes, what support did your child get? When did it start? |
| **Does your child actively avoid reading or writing?**<br><br>e.g gets you to write or read things for them | Yes/No /NA | If yes please give details, including when it started |
| **Has your child ever been reluctant to attend nursery/school?**<br><br>e.g complaining of tummy aches to try and get off school? School refusal? Change of behaviour when getting ready? | Yes/No | If yes please give details, including when it started |
| **Have your child's teachers had any concerns about problem behaviours or distress <u>at</u> school?** | Yes/No | |
| **Has your child ever had problem behaviours or distress <u>immediately after returning home</u> from school?** | Yes/No | |
| **Has your child ever been bullied?** | Yes/No | |
| **Has your child ever regularly missed school?** | Yes/No | |
| **Have <u>you</u> ever had any concerns about your child's social relationships, friendships, or ability to get on with peers at school?** | Yes/No | If yes please give details, including when it started |
| **Have your child's <u>teachers</u> ever had any concerns about your child's social relationships, friendships, or ability to get on with peers at school?** | Yes/No | |

# Section 6: Tics

| | | | | |
|---|---|---|---|---|
| **Does your child have <u>sudden</u>, <u>repetitive</u>, <u>uncontrollable</u> movements or noises such as:** | Blinking (exaggerated and frequent) | | Wrinkling nose or grimacing with their face | |
| | Clicking their fingers | | Touching other people or things | |
| | Jerking or banging their head | | Coughing, grunting, sniffing or throat clearing | |
| | Repeating a sound, word or phrase | | Sudden movement of arms and legs (kicks, hand flicks, etc) | |
| | Other: | | | |

**If you have ticked any of the above, please answer the following questions. If not, proceed to section 7.**

| | | |
|---|---|---|
| **Does your child report a sensation or urge that makes them do these movements?** | Yes/No | If yes, can they describe what the sensation/urge is like? |
| **Does your child report trying to suppress these movements?** | Yes/No | If yes, can they do this? For how long? |
| **Does anything make them more likely?** Certain times? Certain moods? | Yes/No | If yes, please specify: |
| **What age did they start?** Or, when did you first notice them? | | |
| **How often do they occur?** | | |
| **Do they cause any pain, interfere with everyday life, or cause your child problems?** | Yes/No | If yes, please specify: |
| **Do you or your child have a strategy for managing these?** | Yes/No | If yes, please specify: |

# Section 7: Your Child's Relationships

| | | | | |
|---|---|---|---|---|
| **Who is your child closest to?**<br>Do they have one person in particular that is most important to them? | | | | |
| **How does your child <u>show</u> that this person is most important to them?** | | | | |
| **What happens if your child is separated from the most important person to them?**<br>Are they upset? Not bothered? Uneasy? Confident? Is it different in different situations? | | | | |
| **Are there other people your child is close to? Who are they?** | | | | |
| **If your child is hurt or scared, what will they do?**<br>Will they find someone to comfort them or wait to be comforted? Who would they go to for comfort? | | | | |
| **What can help comfort your child?**<br><br>Does it take them longer to calm down than other children their age?<br><br>Are they ever resistant to being comforted? | | | | |
| **In a new place or situation does your child:** | Cling onto you, or be in close contact with you | | Will explore, but keeps you in sight and regularly 'check in' | |
| | Wander off independently, but occasionally checks in | | Wander off, seeming unfussed about knowing where you are | |
| **What is your child like around unfamiliar adults, or people they don't know?**<br><br>Are they friendly? Shy? Do they go up to strangers they don't know? Do they seem wary/cautious? Are they too friendly? Do they go to them to be comforted? | | | | |
| **Does your child ever seem wary or a bit afraid of any parents, caregivers, or other important people in their life?** | | | | |

# Section 8: Difficult Life Events

Life isn't easy, and many children and families will experience difficult life events. We appreciate the following questions may be difficult to answer, but it is really important we know about them so we can help you and your child. We know that parents will always do their best to protect children from difficult life events, however even if you think your child wasn't aware of something, please include it. If you prefer, you can talk about these difficulties in person.

| **Has your child experienced any of the following?** | | |
|---|---|---|
| **Conflicts and stress in the family**<br><br>e.g regular arguments, parents separating, money worries, serious emotional or behavioural difficulties in a family member | Yes/No | If yes to any, please specify age/details |
| **Prolonged or unexpected separation from a caregiver**<br><br>e.g due to hospitalisation, illness, military tours, prison sentence, or separated parent moving away | Yes/No | |
| **Serious injury, illness or death of a close relative** | Yes/No | |
| **Accommodation issues**<br><br>e.g frequently moving home, needing temporary accommodation, seeking shelter, lack of space, etc. | Yes/No | |
| **May have witnessed physical, emotional, sexual abuse or neglect?** | Yes/No | |
| **May have experienced any physical, emotional, sexual abuse or neglect?** | Yes/No | |
| **Has your child experienced any other events which they found very scary, upsetting, or difficult to understand?** | Yes/No | If yes to any, please specify age/details |
| **Has your child ever had a sudden change in behaviour?**<br><br>Did any significant events happen just before this? | Yes/No | |

# Section 9: Daily Living Skills

This section is about your child's daily living skills, such as looking after themselves, keeping safe, remembering information, and learning from their mistakes. Please **look through all questions in this section**. If you think your child **might have <u>any</u> difficulties in this area please answer <u>all</u> questions in this section**. If you don't think this section is relevant to your child, proceed to section 10

| | | |
|---|---|---|
| **Did your child seem late in becoming toilet trained?**<br><br>(Most children are toilet trained during the day by age 3, and during the night by age 5, but may still have accidents) | Yes/No | Do you remember at what age they were toilet trained during the day?<br><br>During the night? |
| **Does your child seem or "feel" like a child who is older or younger than their age?** | Yes/No | If yes, how old?<br><br>Does this vary depending on situation/environment? How? |
| **Do you have concerns about your child's ability to learn or carry out tasks of daily living?**<br><br>e.g cleaning themselves, choosing correct clothes, tidying, cleaning, cooking, finding their way home, etc. | Yes/No | If yes, please describe/give examples: |
| **Do you have concerns about your child's social vulnerability?**<br><br>e.g unaware of being bullied, unaware they are being taken advantage of, gives money away when asked for it. | Yes/No | |
| **Do you have concerns about your child's awareness of danger?**<br><br>e.g unaware of stranger danger, hot pans, road safety, knives, electrical equipment. | Yes/No | |

| | | |
|---|---|---|
| **Do you have concerns about your child's short-term memory?**<br><br>e.g do they have difficulty keeping track of conversations, remembering simple instructions, or remembering what they were in the middle of doing? | Yes/No | If yes, please describe/give examples: |
| **Does your child need a lot more time and repetition to learn information?**<br><br>e.g do they struggle to learn from their mistakes? Do they learn something but forget it the next week? Do they make the same mistakes over and over? | Yes/No | |
| **Do you have concerns about your child's ability to understand things or ideas you can't see or touch?**<br><br>e.g thinking about the future, imagining things that are not real, or understanding things like time, feelings, and money. | Yes/No | |
| **Do you have concerns about your child's ability to apply learning from one situation to another?**<br><br>e.g able to queue in a dinner hall, but not queue in a shop. Able to ask to go to the toilet at home, but not at school. | Yes/No | |
| **Do you have concerns about your child's long-term memory for things they have done?**<br><br>e.g Can they remember what happened at their last birthday, holiday, Christmas, etc? Can they remember what they had for dinner yesterday? | Yes/No | |

# Section 10: Motor Skills

This section is about your child's motor skills, such as learning to walk, catching a ball, riding a bike, using cutlery and tying shoelaces. Please **look through all questions in this section**. If you think your child **might have <u>any</u> difficulties in this area please answer <u>all</u> questions in this section**. If you don't think this section is relevant to your child, proceed to section 11

| **Did your child seem late in starting to...**<br>(Most children sit unsupported by 9 months, crawl by 12 months, and walk by 18 months) | | |
|---|---|---|
| ...Sit unsupported? | Yes/No | Comments/age (if known): |
| ...Crawl? | Yes/No | |
| ... Walk? | Yes/No | |

| | | |
|---|---|---|
| **Do you have concerns about your child's ability to make small accurate movements using their hands and fingers?**<br><br>e.g tying shoe laces, fastening buttons, or holding a pencil | Yes/No | If yes, please describe/give examples |
| **Do you have concerns about your child's ability to make co-ordinated whole body movements?**<br><br>e.g catching or kicking a ball, sitting upright, walking, running, skipping, climbing, etc | Yes/No | |
| **Do you have concerns about your child's handwriting**<br><br>e.g very laboured, complaining of pain, messy, looks immature | Yes/No | |
| **Do you have concerns about your child's ability to tell left from right?** | Yes/No | If yes, please describe/give examples |
| **Does your child sometimes do things with their non-dominant side (with "the wrong hand")?**<br><br>e.g, are they right handed, but use their left hand to throw a ball? | Yes/No | |

# Section 11: Sensory Processing

This section is about your child's sensory processing. For example, whether they particularly like or dislike certain sounds, smells, or types of touch, and how they respond to heat, cold and pain. Please **look through all questions in this section**. If you think your child **might have <u>any</u> difficulties in this area please answer <u>all</u> questions in this section**. If you don't think this section is relevant to your child, proceed to section 12.

| **Has your child shown any of the following behaviours?** (you can circle or cross out examples if this is helpful) | | | |
|---|---|---|---|
| **Vision** | Squints, covers their eyes, or avoids bright, flashing lights. Prefers the dark. | Yes/No | How does this impact your child on a day-to-day basis? Age started/finished? |
| | Being fascinated with lights, patterns, shiny things, watching water fall, spinning things. Looks very carefully at things, close up or in detail. | Yes/No | |
| **Hearing** | Covered their ears to sound. Finds any noise (even quiet background noise) distracting. | Yes/No | How does this impact your child on a day-to-day basis? Age started/finished? |
| | Plays music loud or likes making noise (particularly unusual noises). Doesn't always hear what you say/respond when you call their name. | Yes/No | |
| **Touch** | Extreme dislike of hair brushing or cleaning teeth. Complaining clothes are scratchy or uncomfortable. Hates getting wet or messy. Dislikes light touch or deep pressure. | Yes/No | How does this impact your child on a day-to-day basis? Age started/finished? |
| | Always touching everyone and everything, enjoys walking barefoot outside, doesn't notice if they are messy. | Yes/No | |

| | | | |
|---|---|---|---|
| **Taste/smell** | Very restricted diet. Only eats certain flavours or textures. Often gags on (new) foods or smells. | Yes/No | How does this impact your child on a day-to-day basis? Age started/finished? |
| | Often smells things that aren't for eating. Seeks out strong flavours, smells, or certain foods. | Yes/No | |
| **Balance** | Hates being upside down or travelling in a car. Avoids using playground equipment. Keeps head upright at all times (e.g even when swimming). Holds onto things as if to keep their balance when they don't need to. | Yes/No | How does this impact your child on a day-to-day basis? Age started/finished? |
| | Loves riding a bike, theme park rides, playground equipment. Spins around and around. Rocks back and forth. Always on the go. | Yes/No | |
| **Body awareness** | Accident prone. Trips up a lot. Holds onto things for balance. Grips things too hard or not hard enough. | Yes/No | How does this impact your child on a day-to-day basis? Age started/finished? |
| | Turns their whole body to look at you. Always climbing/running/on the move. Enjoys rough and tumble play but may not know their own strength. | Yes/No | |
| **Hot, cold and pain** | Seems very sensitive to certain temperatures – often complaining of being too hot or too cold. Very sensitive to pain. Slightest scratch is unbearable. | Yes/No | How does this impact your child on a day-to-day basis? Age started/finished? |
| | Oblivious to temperature. Will wear t-shirt in the snow and not notice feeling cold. Will have significant injuries (big cuts, broken fingers, etc) without apparently feeling any pain. | Yes/No | |

# Section 12: Communication Skills

This section is about your child's communication skills, such as their understanding of what other people say, and their ability to use language to express themselves. It also includes your child's ability to understand and use gestures, body language, and other non-verbal communication. Please **look through all questions in this section**. If you think your child **might have <u>any</u> difficulties in this area please answer <u>all</u> questions in this section**. If you don't think this section is relevant to your child, proceed to section 13.

| | | |
|---|---|---|
| **<u>Before your child learned to talk</u>, how did they communicate with you to get what they wanted or needed?**<br><br>e.g gesture, pointing, language, facial expressions, etc. | | |
| **How does your child communicate with you now?**<br><br>e.g do they talk? Do they use gesture, pointing, facial expressions etc? | | |
| **Did your child babble?**<br><br>e.g 'ma', 'ba', 'pa', 'ga', 'da' | Yes/No | If yes, do you remember what age they started? |
| **What were your child's first words?** | | |
| **Did your child's first words seem late?**<br>(Most children's first words are at around 12-15 months) | Yes/No | Do you remember what age? |
| **Did your child lose some or all of their communication skills?**<br><br>e.g stop using the sounds, words or phrases <u>they had already learned</u>? | Yes/No | If yes, at what age? Was there an explanation for this?<br><br>Did they ever regain these language skills? If so, how long did it take? |
| **Does your child have difficulties understanding what other people have said?**<br><br>e.g, needing people to repeat instructions, use small words, or use visual prompts (such as gestures, signs, photos), etc? | Yes/No | If yes, please describe/give examples |
| **Does your child need more time to process what they have heard, or to work out what to say?** | Yes/No | |

| | | |
|---|---|---|
| **Do you have concerns your child's vocabulary is limited, or young for their age?** | Yes/No | If yes, please describe/give examples |
| **Are there times your child cannot use spoken language to express themselves?**<br><br>For example, can't find the right words, can't structure the sentence, etc? | Yes/No | |
| **Does your child muddle up the order of words in sentences, or make grammatical errors?**<br><br>e.g "I *goed* up the hill" when they mean "I *went* up the hill", or saying "I *be* writing" when they mean "I *am* writing" | Yes/No | |
| **Does your child ever mix up "you", "me", and "I" words, or refer to themselves by name?**<br><br>e.g saying "*you* want milk?" when they mean "*I* want milk". Or saying "*James* is running" when they mean "*I* am running". | Yes/No | |
| **Is it sometimes hard to 'tune in' to your child's speech? Do you or other people sometimes have difficulty understanding what your child is saying?** | Yes/No | |
| **Does your child have difficulties understanding non-verbal communication?**<br><br>If you pointed to something, would your child look to where you were pointing? If their teacher gave them a 'look' would they know to stop talking? | Yes/No | If yes, please describe/give examples |
| **Does your child have difficulty using tone of voice and rhythm to add to their communication?**<br><br>For example, "I want *biscuits* now" vs "I want biscuits, *now!"* | Yes/No | |
| **Does your child have difficulties using non-verbal communication?**<br><br>e.g do they point? Do they use their hands to add emphasis to what they are saying? Do they turn their body towards people when they talk to them? | Yes/No | |

# Section 13: Activity and Impulsivity

This section is about your child's activity levels, and impulsivity. This is section is particularly relevant to children who always seem to be on the go, or who do or say things without thinking. Please **look through all questions in this section**. If you think your child **might have <u>any</u> difficulties in this area please answer <u>all</u> questions in this section**. If you don't think this section is relevant to your child, proceed to section 14.

| | | |
|---|---|---|
| **How long can your child <u>sit</u> for?**<br>e.g when watching TV, eating a meal, or doing some work. | | |
| **Are they always getting up to get something or go to the toilet? Do they keep leaving their seat for no reason?** | Yes/No | If yes, please describe. |
| **Can your child wait their turn?** | Yes/No | If no, why not? Do they not understand turn taking yet? Do they get frustrated? Do they forget it isn't their turn? |
| **Does your child seem to have a lot more energy than other children their age? Are they "Full of beans"?** | Yes/No | If yes, what kind of things are they doing with all this energy? |
| **Does your child do a lot of fidgeting, squirming, fiddling with things around them, jiggling their legs, etc?** | Yes/No | If yes, what do they do? When do they do this most/least? |
| **Does your child <u>say or do things</u> without thinking?**<br><br>e.g talking back to teachers, shouting out answers, saying inappropriate things, butting into games/conversations, crossing the road without looking, starting things they won't finish etc. | Yes/No | If yes, how often does this happen? Please give examples. |

# Section 14: Attention and Focusing

This section is about your child's ability to pay attention. This includes things such as focusing on one activity for a good time without getting distracted, keep track of their belongings, and checking that they are doing something correctly. Please **look through all questions in this section**. If you think your child **might have <u>any</u> difficulties in this area please answer <u>all</u> questions in this section**. If you don't think this section is relevant to your child, proceed to section 15.

| | | |
|---|---|---|
| **What activity can your child focus on for the longest time?** (<u>Do NOT include video/ phone/ tablet games</u>)<br><br>e.g tv programmes, playing a (not screen-based) game or sport, conversation or playing with friends, etc? | How long can they focus on just this before becoming distracted and move on? | |
| **Does your child regularly lose or forget to bring things?**<br>e.g leaving their PE kit, school bag, or lunch box at school? Leaving toys or their phone behind when visiting friends or family, etc | Yes/No | If yes, how often does this happen? Please give examples. |
| **Does your child regularly make careless or 'silly' mistakes?**<br><br>e.g not reading a homework question properly, forgetting or missing out steps in a task, etc. | Yes/No | If yes, how often does this happen? Please give examples. |
| **Does your child usually pay attention when you or others are speaking to them?**<br><br>Even if they aren't looking at you, or are doing something else, are they able to *listen* and respond/remember what you said? | Yes/No | If no, how often does this happen? Do any situations make this more or less likely? |
| **Can your child focus their attention on a task when they need to?**<br><br>e.g completing homework, watching the traffic/traffic lights to see when it is safe to cross the road, to listen to important instructions, etc. | Yes/No | If no, please give examples. |

# Section 15: Social Skills and Friendships

This section is about your child's ability to make and keep friends, understand 'social rules', get on with others. Please **look through all questions in this section**. If you think your child **might have <u>any</u> difficulties in this area please answer <u>all</u> questions in this section**. If you don't think this section is relevant to your child, proceed to section 16.

<table>
<tr><td colspan="2">Tell us about your child's friendships<br><br>Do they have many friends?<br><br>What do they do together?<br><br>Does your child sit back, or take the lead? Do they share? Do they always tell others what to do?</td><td rowspan="4">Please describe/give examples:</td></tr>
<tr><td>Does your child have difficulty making new friends?</td><td>Yes/No</td></tr>
<tr><td>Does your child frequently fall out with their friends?</td><td>Yes/No</td></tr>
<tr><td>Does your child want to see their friends outside of school?<br><br>e.g do they ask to have sleepovers or visit a friend's house? Do they meet friends at the park, cinema, etc?</td><td>Yes/No</td></tr>
<tr><td>Does your child make good eye contact with <u>you</u>?</td><td>Yes/No</td><td rowspan="5">If no, please describe/give examples:</td></tr>
<tr><td>Does your child make good eye contact with <u>other people</u>?</td><td>Yes/No</td></tr>
<tr><td>If <u>you</u> smile at your child, does your child smile back?</td><td>Yes/No</td></tr>
<tr><td>If <u>someone else</u> smiles at your child, does your child smile back?</td><td>Yes/No</td></tr>
<tr><td>Can <u>you</u> tell how your child is feeling from their face?</td><td>Yes/No</td></tr>
</table>

| | | |
|---|---|---|
| **Can <u>other people</u> tell how your child is feeling from your child's face?** | Yes/No | |
| **Can your child tell how <u>you</u> are feeling from your face?** | Yes/No | |
| **Can your child tell how <u>other people</u> are feeling from their face?** | Yes/No | |
| **Is your child interested in other children?** | Yes/No | |
| **Can your child hold a conversation about a topic they like?**<br><br>e.g take turns, consider what another person does/doesn't already know when telling them something, not start 'in the middle' of a conversation, | Yes/No | If no, please describe/give examples: |
| **Can your child hold a conversation on a topic someone else is interested in?**<br><br>e.g show interest, ask questions, make comments, not turn the topic back to their own interests | Yes/No | |
| **Does your child seem to make lots of social mistakes?**<br><br>e.g says the wrong thing, accidently offending somebody, blurting out something inappropriate in public, not following the social rules. | Yes/No | If yes, please describe/give examples: |
| **If out and about and your child saw someone they know, would they smile and say hello?**<br><br>e.g a family member, someone from school, etc) | Yes/No | |

# Section 16: Routines, Rituals, and Special Interests

This section is about your child's ability to cope with change to their daily routines, or if they have any particular rituals that have to be done a certain way. It also includes questions on repetitive behaviours and any particularly strong or unusual interests your child might have. Please **look through all questions in this section**. If you think your child **might have <u>any</u> difficulties in this area please answer <u>all</u> questions in this section**. If you don't think this section is relevant to your child, proceed to section 17.

| | | |
|---|---|---|
| **Does your child have any rituals that they need to do a certain way?**<br><br>e.g bedtime routine, eating food in a specific order, saying goodnight to cuddly toys. Has to respond with a certain phrase. | Yes/No | If yes, please describe/give examples: |
| **Can your child cope when their rituals are not done this way first time?**<br><br>e.g dad puts them to bed rather than mum. Food touches on a plate, cuddly toy missing, mum says "have a good day" rather than "have a nice day" | Yes/No<br>N/A | If no, what happens? |
| **Can your child cope with planned changes to routine?**<br><br>e.g school holidays or days out. Do you have to prepare them for change? If so, how? | Yes/No | If no, please describe/give examples: |
| **Can your child cope with unplanned changes to routine?**<br><br>e.g car breaks down, someone needs a doctor's appointment. | Yes/No | If no, what happens? |

| | | |
|---|---|---|
| **Does your child need some things to be the same every day?**<br><br>e.g needing a certain plate for dinner, need to go to school the same route, need to eat the same food on specific days. | Yes/No | If yes, please describe/give examples: |
| **Does your child have any repetitive behaviour?**<br><br>e.g watching the same part of a video over and over. Acting out the same story with toys over and over. | Yes/No | If yes, please describe/give examples: |
| **Does your child know more about certain topics than most children their age?**<br><br>e.g knowing all the footballers in the premier league and their stats. Knowing all about different types of planes. Knowing about all the different breeds of horses. Knowing everything about a certain friend or pop star. | Yes/No | If yes, please describe/give examples: |
| **Does your child have any <u>unusual</u> interests, or interests which seem immature for their age?**<br><br>e.g telephone pylons, types of ships, a teenager knowing lots about Thomas the Tank Engine or Pingu. | Yes/No | |

# Section 17: Emotions, Behaviour, and Mental Health

This section is about your child's emotional and mental wellbeing, and their behaviour when they are upset or distressed. Please **look through all questions in this section**. If you think your child **might have <u>any</u> difficulties in this area please answer <u>all</u> questions in this section**. If you don't think this section is relevant to your child, proceed to section 18.

<table>
<tr><td colspan="2">What does your child enjoy doing?</td><td colspan="2"></td></tr>
<tr><td colspan="2">Does your child attend any out of school clubs or activities? How do they get on?</td><td colspan="2"></td></tr>
<tr><td colspan="2">In the last year, has your child had any significant tantrums or meltdowns?<br><br>e.g crying, screaming, shouting, etc</td><td>Yes/No</td><td>Are they much more intense than for other children their age?<br><br>How often do they happen?<br><br>How long do they last?</td></tr>
<tr><td rowspan="3">If yes, please tell us more about what these tantrums or meltdowns look like</td><td>Before</td><td colspan="2">What triggers them? When and where do they tend to happen?</td></tr>
<tr><td>During</td><td colspan="2">What do they do? What do you or other people do? What makes it better or worse?</td></tr>
<tr><td>After</td><td colspan="2">What makes them stop? What does your child do after? What do you or other people do after?</td></tr>
</table>

| | | |
|---|---|---|
| **Has your child ever had any behaviours which were particularly challenging?**<br><br>e.g. kicking, spitting, throwing, head banging? | Yes/No | If yes, please describe and give approximate ages: |
| **Now, or in the past, has your child...** | | |
| **Regularly or routinely lied?** | Yes/No | If yes, please give rough ages, details, and any support given: |
| **Ever smoked, drunk alcohol, or used non-prescription drugs?** | Yes/No | |
| **Had any signs or symptoms of low mood, or been overly tearful?** | Yes/No | |
| **Had signs or symptoms of significant stress, worry, anxiety or panic?** | Yes/No | |
| **Had their overall day-to-day mood, personality or demeanour change significantly?** | Yes/No | |
| **Acted like they can see or hear things which others can't see or hear?** | Yes/No | |
| **Described any unusual thoughts or beliefs?** | Yes/No | |
| **Ever attempted or succeeded in deliberately harming themselves?** | Yes/No | |
| **Ever had any suicidal thoughts?** | Yes/No | |
| **Ever had any plans to end their life?** | Yes/No | |
| **Ever attempted suicide?** | Yes/No | |

# Section 18: Sleep

This section is about your child's sleep. It includes questions about difficulties getting to sleep or staying asleep, as well as issues such as nightmares and sleepwalking. Please **look through all questions in this section**. If you think your child **might have <u>any</u> difficulties in this area please answer <u>all</u> questions in this section**. If you don't think this section is relevant to your child, proceed to section 19.

| | **On weekdays** | **On weekends** |
|---|---|---|
| **When does your child wake up?** | | |
| **When does your child go to sleep?** | | |

| | | |
|---|---|---|
| **Does your child have naps, or seem tired during the day?** | Yes/No | If yes, what time and for how long? When do they seem tired? |
| **What is your child's bedtime routine?** | Please give details and rough timings: | |
| **Does your child share a bedroom?** | Yes/No | If yes, with who? |

| | | |
|---|---|---|
| **Does your child require anything special in their bedroom to help them sleep?**<br><br>e.g teddy, a music tape, a sleeping bag, lavender, glass of water, etc | Yes/No | If yes, what? |
| **Is your child able to settle and go to sleep soon after being put to bed?** | Yes/No | If no, how long are they up for? What do they do? |
| **Does your child regularly wake in the night?** | Yes/No | If yes, how often? At what time? At what age did it start? What do they do when they wake up? |
| **Does your child suffer from regular nightmares?** | Yes/No | If yes, how often? Do you know what they are about? |
| **Does your child have any sleep issues, or other difficulties with sleep?**<br><br>e.g night terrors, sleep walking, etc. | Yes/No | If yes, please give details: |
| **Does your child's sleep difficulties cause difficulties for the rest of the family?**<br><br>e.g parent or siblings missing sleep. | Yes/No | If yes, please describe/give examples: |

# Section 19: Seizures, Convulsions, and Faints

| | | |
|---|---|---|
| **Has your child ever had <u>any</u>:**<br>- Seizures<br>- Convulsions<br>- Fits<br>- Faints<br>- Vacant spells/staring episodes | Yes/No | If yes, please specify age/details: |
| **Has your child ever been assessed for or diagnosed with having**<br>- Febrile seizures/convulsions<br>- Epilepsy<br>- Non-epileptic seizures<br>- Paroxysmal events | Yes/No | |
| **If you answered yes to either question**, please complete all questions in this section. If you answered no to both of the above, proceed to section 20. | | |

**Main questions**

| | | |
|---|---|---|
| **When did your child have their first fit, faint, "funny spell", etc?** | Please tell us about what happened that first time, and what help was given: | |
| **Is there anything you think triggers an episode?** | Yes/No | What? |
| **What happens during the episode?** *(Please give description, not medical terms/classification)*<br><br>e.g Were they responsive during? Did they fall? If there are movements, what are they like? Did they experience any signs or sensations? | Please describe | |

| | | |
|---|---|---|
| **What happens after the episode? How long until they returned to normal?** | | |
| **Have you noticed any loss of skills after a single or cluster of episodes?** | Yes/No | If yes, what skills? Did they return? How long did it take? |
| **Do you think there is anything that makes the episodes worse?** | Yes/No | If yes, what? |
| **Have they changed over time?** | Yes/No | If yes, how? |
| **Have there been any investigations** (such as EEGs)**?** | Yes/No | What was done? What were the results? |
| **Have you been given any management advice about these episodes?** | Yes/No | What advice has been given? |
| **Are there health professionals currently involved in reviewing these episodes?** | Yes/No | Who? |

# Section 20: Eating, Drinking and Weight

This section is about your child's eating, drinking and weight. It includes questions relevant to children who have a restricted diet or eat non-food items, who have difficulties with chewing and swallowing, who are over or under weight. Please **look through all questions in this section**. If you think your child **might have any difficulties in this area please answer all questions in this section**.

If you don't think this section is relevant to your child, you have completed the form. **Please go to the front page and fill in the 'date completed' field.**

| | | |
|---|---|---|
| **Does your child eat less than 20 different foods?** | Yes/No | If yes, please give details on what they will/won't eat, and how it has changed: |
| **Do you have concerns about your child's nutrition?** | Yes/No | |
| **Has your child's eating changed over the last 6 months?** | Yes/No | |
| **Will your child accept multivitamin supplements?** | Yes/No | |
| **Does your child eat any non-food items.**<br><br>e.g moss, stones, ash, hair, paper, blu-tac, soap, etc | Yes/No | If yes, what non-foods do they eat? |
| **Does your child have difficulties with chewing, swallowing, or choking on their food?** | Yes/No | Please give details: |
| **Does your child appear anxious around eating or meal times?** | Yes/No | If yes, when did it start? What do they do? How do you manage it? |

| | | |
|---|---|---|
| **Does your child have a preference for particular food textures?**<br>e.g dry/crunchy? | Yes/No | If yes, which textures? |
| **Are you concerned your child may be underweight/ overweight?** | Yes/No | If yes, what is their current **weight** and **height**?<br><br>How has their weight changed over the last 6 months? |
| **Are you worried your child drinks too much or too little?** | Yes/No | If yes, please give details, including any change over time: |

**Thank you for taking the time to complete this form. The information you have provided will help us support you and your child.**

**<u>Please go to the front of the form and fill in the 'date completed' field</u>**

<u>About the F-NDQ Child Form Version 2</u>

The F-NDQ Child Form Version 2 was developed in collaboration between the Paediatric, Clinical Psychology, Psychiatry, Speech and Language Therapy, Occupational Therapy, Dietetics, Epilepsy and Nursing services in NHS Fife, and designed by Dr Joshua Muggleton. It provides a core multidisciplinary neurodevelopmental assessment for children.

Clinicians' questions regarding the development and administration of the F-NDQ should be sent to **fife.f-ndq@nhs.scot**. Correspondence should not include confidential patient information. Any patient queries regarding the F-NDQ (such as how to fill it in, where to send it, and if it has been received), should be directed to the clinician who provided you with the F-DNQ.