Child Health and Education in the Seventies

A national study in England, Wales and Scotland of all children born 5th–11th April 1970

Under the auspices of the University of Bristol
and the National Birthday Trust Fund

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CONFIDENTIAL

DEVELOPMENTAL HISTORY SCHEDULE

Health District Code VAR5505 | Child's Local Serial Number | Child's Central Survey Number VAR5501

SINGLETON OR TWIN = VAR5502

Full Name of the Child ..... **Sex** VAR5503

Address ..... **Date of birth** VAR5504 **April 1970**

.....

If moved into present Health Authority/Board since birth, please give:

(a) name of previous A.H.A./L.H.A., or Health Board .....

(b) age (approx. in years and months) of N when moved to present

A.H.A./L.H.A./Health Board .....

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Notes for Completion of Schedule

1. Aims

The purpose of this Schedule is to obtain data on the utilisation by the study child of child health clinics, health visiting facilities, developmental screening tests and other important aspects of the community health services. As parental recall of past events is often incomplete, reference to pre-school child health records is also essential as a means of confirming and supplementing information obtained by the Health Visitor in the home interview.

2. Person(s) Completing Schedule

Ideally the Health Visitor who is carrying out the home interview should also complete this schedule. Some of the information may require access to records usually held centrally, such as in Area or District Offices or in Health Boards (Scotland), e.g. special handicap records, centrally held registers. The personnel used and arrangements made for completion will doubtless be decided by the Area or District officer responsible according to local contingency.

3. Records Required

(a) The following basic types of records are essential for the main part of this schedule.

(i) Records used by health visitor to record health visiting, e.g. Home Visiting records, Consultation Record Cards and, where available, Family Records. These will be referred to as H.V. records,

(ii) Records used in Child Health Clinics or Child Welfare Clinics by doctors to record developmental screening and other health care, e.g. MCW 46. These will be referred to as C.H.C. records.

(b) Some questions require reference to other sources, in addition to the above basic records – for children for whom there may be letters or reports indicating past hospital outpatient attendances or inpatient care, children who are on observation or other registers, children who have been assessed for special educational treatment and other children who have handicaps or disabilities. In some instances, this information will be available in H.V.'s or C.H.C. records, but arrangements will probably be necessary for this to be supplemented from records or information held centrally.

(c) Records about developmental screening are needed for question 4. The majority of general developmental check-ups and specific screening tests will be recorded on records used by doctors in Child Health Clinics and on H.V. records. Additional information about any developmental check-ups at G.P. practices or health centres would be valuable, and may be readily available to health visitors attached to G.P. practices. Developmental check-ups are sometimes carried out elsewhere, e.g. at hospital birth follow-up clinics, and vision and hearing are often screened during routine medical examination at day nursery, nursery and infant school. This information would be appreciated if it is readily available.

4. Developmental Screening & Assessment

Developmental screening in Q.4 refers to check-ups usually routinely performed on all pre-school children to identify those who may be developmentally delayed or have a suspected vision or hearing defect.

Developmental assessment in Q.5 refers to a much more detailed examination of development, which is usually only performed on children who have already been identified as having a possible delay or defect in hearing, vision or other aspect of development.

What to include as Developmental Screening in Q.4 Part I

(a) Any record of a routine general developmental examination or a check-up of overall developmental progress.
This term does not refer to an isolated single screening test, though specific screening tests may often be included in the general observations and examination made of the child's developmental achievements. General developmental examinations or check-ups of overall developmental progress are usually carried out at or near prescribed ages in C.H.C., home or G.P.'s practices by doctor or health visitor. The result is often entered on C.H.C. or H.V. records under several headings of 'developmental' function e.g. hearing and language, posture and locomotion, vision, social behaviour, or may be entered in the form of observations of individual developmental achievements of the child, e.g. sitting, smiling, saying single words, etc. If neither of these forms of recording are present in the notes, but it is definitely indicated that a general developmental check-up was made, this should be included. Please include also any record you may have of a general medical examination or check-up carried out by a doctor at nursery or infant school.

(b) Any record of tests for vision, hearing or squint.
Vision and hearing may be tested on their own or as part of a general developmental examination or check-up of overall developmental progress. They are routine clinical procedures used for testing these special functions, e.g. routine testing of hearing by rattle, paper etc. by H.V. at 7–9 months, screening of vision by Stycar 5-letter test at age 3 years. If the details of the type of test used are not clear but the records indicate that vision, hearing or both have been checked, such entries should be included as vision or hearing tests.
Any record that there has been a check-up for a squint should be entered separately as "examination for squint" and not be entered as a vision test in section b of the table in Q.4. Include as "examination for squint" any occasion where records indicate a specific test was made, e.g. cover test or light reflection test, or where the records indicate only if a squint was, or was not, evident in the course of a general examination. Records of any such test(s) for vision, hearing or squint carried out at nursery or infant school should also be included.

(c) Please exclude from Q.4 Part I any remarks or observations of developmental progress made at times **other than** the developmental screening examinations and tests described above. Details of these should be entered in Q.4 Part II.

5. General Notes

(a) Every question should be answered.

(b) Please base your answers only on information which is contained in the record form(s), registers etc. There is space provided below each question for you to add any information known to you from other sources.

(c) If you have any difficulty in interpreting or reading the relevant entry on records, ring code marked "records unclear" and give details in the space for "comments" at the end of the question.

(d) If you do not have the relevant record(s) at all when answering a question, please ring code marked "No records".

(e) Allowance should be made for the fact that the format of every question inevitably cannot correspond with all the different recording systems in use throughout the country. Space is therefore provided at the end of each question for comments, and for supplying extra data such as:

(i) additional information known to you but not on the records;

(ii) details of any difficulties with obtaining or interpreting the data on the relevant record;

(iii) other observations, e.g. where the information given on records is considered not to reflect a true picture of the actual events.

(f) Some abbreviations are used in this schedule, e.g.

Study Child	N
Health Visitor records	H.V. records
Child Health Clinic records used by doctor ...	C.H.C. records
Local Health Authority	L.H.A.
Area Health Authority	A.H.A.
Phenylketonuria	P.K.U.
Question	Q

(g) Further details about C.H.E.S. and on the completion of questions are given in "Survey Notes and Information".

ALL INFORMATION RECORDED ON THIS SCHEDULE WILL BE TREATED AS STRICTLY CONFIDENTIAL IN ACCORDANCE WITH MEDICAL RESEARCH COUNCIL REGULATIONS AND NO CHILD WILL BE IDENTIFIED OR REFERRED TO IN ANY REPORT BY NAME.

1. Do the Health Visitor's records or child health clinic records indicate that N has ever had for any reason whatsoever –

	Yes	No	Records unclear	No records	
(a) any home visit from H.V.? VAR5506	1	2	3	0	(16)
(b) any attendance at C.H.C.? VAR5507	1	2	3	0	(17)

If yes to either of above, please give further details:

	First H.V. home visit*	First C.H.C. attendance	
(c) Give date of first H.V. visit* and first C.H.C. attendance for any reason whatever.	VAR5508	VAR5511	18–22 / 23–27

(d) Give the total number of visits from H.V. and N's C.H.C. attendances for any reason whatsoever, in each time-period specified below.

If none, enter NONE.

	Child's age in months	Time period	Total number of H.V. home visits *	Total number of C.H.C. attendances	
First year	0–5	Apr. 1970 – Sep. 1970	VAR5514	VAR5523	28–31
	6–11	Oct. 1970 – Mar. 1971	VAR5515	VAR5524	32–35
Second year	12–17	Apr. 1971 – Sep. 1971	VAR5516	VAR5525	36–39
	18–23	Oct. 1971 – Mar. 1972	VAR5517	VAR5526	
Third year	24–29	Apr. 1972 – Sep. 1972	VAR5518	VAR5527	40–43
	30–35	Oct. 1972 – Mar. 1973	VAR5519	VAR5528	
Fourth year	36–47	Apr. 1973 – Mar. 1974	VAR5520	VAR5529	44–47
Fifth year	48+	Since April 1974	VAR5521	VAR5530	
		Total since birth	VAR5522	VAR5531	

* *Exclude any visit where no access gained to home and note such visits in "comments" below.*

Comments, e.g. Notes unclear, records absent, extra information, etc.

NO ACCESS H.V. HOME VISITS : VAR5532

SEE PAGE 3a

2. Please state if H.V. or C.H.C. records indicate that N's history contains any risk factors – either as a complication or condition which occurred during the perinatal period (pregnancy, labour, or postnatal in first week), or as a genetic, social or environmental factor.
Include the following type of entries as risk factors.

(i) Any entry of a condition of N in space specially provided on the H.V. or C.H.C. record form for risk (or similarly named) factors, or any entry of a condition specified on the H.V. or C.H.C. record as reasons for inclusion in at risk/observation register.
(ii) Any condition which, though not directly labelled as a risk-factor in the above records, is implied to be a risk factor by virtue of being printed in a check-list of abnormal conditions on the H.V. or C.H.C. record form. One example of such a list is on the front page of C.H.C. record MCW 46.

Include all above conditions, irrespective of whether N's name was actually placed on a Register or not.

Is there any risk factor recorded:

	Yes	No	Record Unclear	No records	
(a) on H.V. records? ... VAR5533	1	2	3	0	(48)
(b) on C.H.C. records? ... VAR5534	1	2	3	0	(49)

If yes to (a) or (b), ring any condition(s) listed below which correspond to risk-factor(s) reported in N's records. Ring risk factor(s) reported from H.V. records separately from C.H.C. records. If any risk factor(s) reported in N's records do not correspond exactly or nearly exactly to any condition listed below, ring the category 'other risk factor' and specify the nature of the risk-factor in the space provided.
Where "combined" record used, with both H.V. and C.H.C. doctor's entries, ring both columns and note "combined record" in comments below.

Ring all that apply in each column	H.V. record	C.H.C. record	*Ring all that apply in each column*	H.V. record	C.H.C. record	
Pregnancy/Delivery			First week of N's life VAR5537 VAR5540			50–52
Rubella in first 4 mths	1	1	Low birthweight	1	1	53–56
Twin pregnancy	2	2	Birth asphyxia	2	2	
Rh or ABO incompatibility	3	3	Jaundice	3	3	
Hypertension, toxaemia	4	4	Convulsions	4	4	57–59
Any pregnancy bleeding	5	5	Any cong. abnorm.	5	5	
Psychiatric illness	6	6	Resp. distress	6	6	60–63
Diabetes	7	7	Other risk factor(s)	7	7	
Gestation under 36/37 wks	8	8	specify.....			
Postmaturity (42 wks+)	9	9	.....			64–66
Breech	10	10	Social or Genetic			
Prolonged/diffic. labour	11	11	Social or environmental			
Foetal distress	12	12	risk factor(s), specify	1	1	
Other risk factor in pregnancy/labour, specify	13	13	..... Genetic risk factor(s), specify	2	2	67–69

VAR5535/6 VAR5538/9

Comments, e.g. Notes unclear, records absent, extra information etc.

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Q1. Do the Health Visitor's records or child health clinic records indicate that N ever had for any reason whatsoever-

Total H.V. visits Year 1= VAR5661
Total H.V. visits Year 2= VAR5662
Total H.V. visits Year 3= VAR5663
Total C.H.C. attendances Year 1= VAR5664
Total C.H.C. attendances Year 1= VAR5665
Total C.H.C. attendances Year 1= VAR5666

Please refer to notes 3(c) and 4(a-c) at the beginning of this schedule concerning Q.s 3–4.

3. Do the records specified below contain any indication that the following have been done?

Is there a record of:		Yes	No	Records unclear	No Records	If yes, specify
From H.V. or C.H.C. records only						
(a) N's birthweight?	VAR5541	1	2	3	4	VAR5542 ..... lbs ....oz or ..... gm
(b) N's gestational maturity?	VAR5543	1	2	3	4	VAR5544 wks
(c) Any congenital defect in N?	VAR5545	1	2	3	4	specify ....
From H.V., C.H.C. & any other records						
(d) Any screening for P.K.U.?	VAR5546	1	2	3	4	
(e) Any screening for CDH (hip)?	VAR5547	1	2	3	4	
(f) Any screening for hearing?	VAR5548	1	2	3	4	
(g) Any screening for squint?	VAR5549	1	2	3	4	
(h) Any screening for vision?	VAR5550	1	2	3	4	
(i) Any gen. devlp. check-up(s)?	VAR5551	1	2	3	4	

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If yes to (f), (g), (h) or (i), please ensure that each test or check-up is entered in Q.4.

Comments, Notes unclear, records absent, extra information, etc.

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4. Part I

Please complete table below for each occasion N received developmental screening (exclude P.K.U./hip tests) – either a general developmental examination or check-up or a screening test of hearing, vision or squint, (see notes on page 2). The following examples illustrate what is required (see table below).

Example A. If it was noted on the H.V.'s record that on 15th November 1970, the H.V. carried out a routine test of hearing at N's home, the entry should be as in Example A.

Example B. If on 8th January 1971 it was recorded by the doctor at the C.H.C. at a nine-month developmental examination that the child had turned right and left to the sound of rattle, paper, spoken voice, had visually followed rolling balls and that his general development was tested, with normal co-ordination, motor and social development, the entry should be as in Example B.

Note that only the fact that N was tested is to be entered in the answer to this question; details of any referral for assessment or for further investigations for suspected delay or abnormality should be recorded in Q.5.

Notes for completion of section (b) in table below.
Whenever records indicate that a routine general developmental check-up or examination was made, ring 1. If a hearing test, a vision test and/or an examination for squint was included as part of this general developmental check-up, ring 2, 3 and/or 4 as appropriate. If a comprehensive developmental scale, e.g. Denver or Griffiths, was used, ring 1, 2 and 3 even though individual components may not be specified; please name any such scale used in "comments" below the table. Ring 2, 3 and/or 4 in section (b) if screening for hearing, vision and/or squint was done on occasion(s) separate from a general developmental check-up.
In answering section (c) below, give the main person responsible if more than one person carried out tests or made observations on any one occasion.

	Examples		Times screened or given check-up									
	A	B	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th
(a) When "screened"?												
Day	15	8	–	–	–	–	–	–	–	–	–	–
Month	11	1	–	–	–	–	–	–	–	–	–	–
Year	70	71	–	–	–	–	–	–	–	–	–	–
(b) What was done?												
Ring all that apply												
Genl. devel. check-up	1	(1)	1	1	1	1	1	1	1	1	1	1
Hearing test	(2)	(2)	2	2	2	2	2	2	2	2	2	2
Vision test	3	(3)	3	3	3	3	3	3	3	3	3	3
Exam. for squint	4	4	4	4	4	4	4	4	4	4	4	4
(c) Who screened N?												
Doctor	1	(1)	1	1	1	1	1	1	1	1	1	1
Health visitor	(2)	2	2	2	2	2	2	2	2	2	2	2
Other or uncertain	3	3	3	3	3	3	3	3	3	3	3	3
Not known who	0	0	0	0	0	0	0	0	0	0	0	0
(d) Where screened?												
Child Health Clinic	1	(1)	1	1	1	1	1	1	1	1	1	1
G.P.'s practice	2	2	2	2	2	2	2	2	2	2	2	2
N's home	(3)	3	3	3	3	3	3	3	3	3	3	3
Nursery/Infant school	4	4	4	4	4	4	4	4	4	4	4	4
Hospital birth follow-up clinic	5	5	5	5	5	5	5	5	5	5	5	5
Other or uncertain	6	6	6	6	6	6	6	6	6	6	6	6

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Comments, e.g. Notes unclear, records absent, extra information, etc.

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Part II

Please enter below the details of any observations of developmental progress which have been made at times other than on the occasions of routine developmental screening examinations or tests, described in Part I. If not known by whom or where observed put NOT KNOWN. If more space required, please continue on back page of schedule.

Date Day Mth Yr	Who observed N? H.V. or Dr.	Where observed C.H.C./home/ G.P.'s etc.	Summary of observations recorded
.../.../...			
.../.../...			SEE PAGE 5a
.../.../...			
.../.../...			

5. Is there any information on available records, reports or letters that N has ever been seen for assessment (see note 4 on second page) or for further tests, as a result of a (suspected) defect in hearing or vision or any other developmental problem? Include assessments in special assessment/handicap centres as well as hospital OP/IP situation.
If assessed as result of developmental screening mentioned in Q.4 ring code 2.
If referred from other source or if not known who referred N, ring code 3.

DETAILS: OBSERVATION OF DEV. PROG. = VAR5552

Recorded to have been seen for:

(a) specialist hearing assessment or further hearing tests ... VAR5553

(b) specialist visual assessment or further eye tests VAR5554

(c) specialist or further assessment for any other developmental problem.* VAR5555

No	Yes, referred: after develop. test (Q.4)	Yes, referred: from other source	Records unclear whether assessed	No records	
1	2	3	4	0	(9)
1	2	3	4	0	(10)
1	2	3	4	0	(11)

*e.g. delay in motor, intellectual, mental, language, social or emotional development.

If yes ringed to (a), (b) or (c), please give details below for each referral.
If records indicate more than three, please continue on back page.

Date	Problem for which referred, diagnosis if recorded, and any further details	Name and address in full of hospital, clinic, or assessment centre
..../..../....	VAR5556	
..../..../....		
..../..../....		

12–14

Comments, e.g. Notes unclear, records absent, extra information, etc.

6. Is there any information on available records, reports or letters that N has ever:

(a) attended hospital outpatients or special(ist) clinic? VAR5557

(b) been admitted to hospital? VAR5558

(c) been in-care, fostered, or in other residential placement? VAR5559

Yes	No	Records unclear	No records	
1	2	3	0	(15)
1	2	3	0	(16)
1	2	3	0	(17)

If yes ringed to (a), (b) or (c), please give any recorded details below for each condition for which seen at hospital or admitted, and for any occasion fostered or in care or other residential placement.
If records indicate more than three, please continue on back page.

Date	Hosp. OP/IP or placement	Details of illness and diagnosis or reason for placement	Name and address in full of hospital or placement
..../..../....	VAR5560		
..../..../....			
..../..../....			

18–20

Comments, e.g. Notes unclear, records absent, extra information, etc.

Q4. Part II

	Date Day Mth Yr	Who observed N? H.V. or Dr.	Where observed C.H.C./home/ G.P.'s etc.	Summary of observations recorder (What was done)
1	VAR5581	VAR5583	VAR5584	VAR5582
2	VAR5585	VAR5587	VAR5588	VAR5586
3	VAR5589	VAR5591	VAR5592	VAR5590
4	VAR5593	VAR5595	VAR5596	VAR5594
5	VAR5597	VAR5599	VAR5600	VAR5598
6	VAR5601	VAR5603	VAR5604	VAR5602
7	VAR5605	VAR5607	VAR5608	VAR5606
8	VAR5609	VAR5611	VAR5612	VAR5610
9	VAR5613	VAR5615	VAR5616	VAR5614
10	VAR5617	VAR5619	VAR5620	VAR5618
11	VAR5621	VAR5623	VAR5624	VAR5622
12	VAR5625	VAR5627	VAR5628	VAR5626
13	VAR5629	VAR5631	VAR5632	VAR5630
14	VAR5633	VAR5635	VAR5636	VAR5634
15	VAR5637	VAR5639	VAR5640	VAR5638
16	VAR5641	VAR5643	VAR5644	VAR5642
17	VAR5645	VAR5647	VAR5648	VAR5646
18	VAR5649	VAR5651	VAR5652	VAR5650
19	VAR5653	VAR5655	VAR5656	VAR5654
20	VAR5657	VAR5659	VAR5660	VAR5658

Total no. screenings= var5580

7. Has N ever had any injury considered or suspected to be "non-accidental"? VAR5561

Yes, has had suspected or confirmed condition of this type	1
No, but has been considered to be "at risk" of this	2
No, never	3
Not known	0

(21)

Comments:.....

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8. Has N's name ever been included on a Register of any sort?
A register is a means of identifying children with special needs or those who require follow-up. It is usually kept in the form of a list, card index, master file or on a computer.
In answering this question, reference should be made, where possible, to information contained in the register concerned in addition to details from C.H.C. or H.V. records or reports.

Yes – VAR5562

on one register	1
on more than one register	2
No, never on any register	3
Not known	0

(22)

If yes, was it because N is/was considered to be: VAR5563

Ring all that apply

"At risk"/in need of observation, for medical reasons?	1
"At risk"/in need of observation, for social reasons?	2
Handicapped?	3
Other situation, specify	4
Reason not known	0

Please give details below from each register on which N's name has ever been placed.
If insufficient space, please continue on back page.

23,24

	First Register	Second Register
(a) Give name by which register known		
(b) Who "keeps" register? *		
(c) Reasons in detail why N included on this register		
(d) Date first put on register		
(e) If taken off, give date		

* Indicate if "peripheral" register, e.g. initiated by and confined in use to a particular clinic; or if a "central" register, e.g. initiated and kept by L.H.A./Area/District or Board.

Comments, e.g. Notes unclear, records absent, extra information, etc.

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9. Has a decision ever been reached by a Local Education Authority that N is in need of 'special educational treatment'?

VAR5564

No –

and not likely to be required	1
but a decision pending	2

Yes –

but waiting for a place	3
and receiving special educational treatment	4
Not known	0

(25)

SEE PAGE 6a

If yes, or if a decision is pending, into which category does child fall?

Ring all that apply in both columns

Blind	1	Severely E.S.N. (Eng. & Wales)	7
Partially sighted	2	Epileptic	8
Deaf	3	Maladjusted	9
Partially hearing	4	Physically handicapped	10
Mentally handicapped (Scotland)	5	Speech defect	11
Educationally subnormal (Eng. & Wales)	6	Delicate (Eng. & Wales)	12

26–29

Comments, e.g. Notes unclear, records absent, extra information, etc.

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Q9. Has a decision ever been reached by a Local Education Authority that N is in need of 'special educational treatment'?

Category of Handicaps I=VAR5565
Category of Handicaps II=VAR5566

10. In summary, is there any indication from records and reports available to you that N has now or has had in the past any developmental problem, or any disability or any handicapping condition — physical, mental or emotional, irrespective of whether condition is mentioned elsewhere in this questionnaire?

Ring all that apply

VAR5567

Yes —
- currently ... 1
- in past ... 2

No ... 3

Not known ... 0

30,31

If **yes**, list each developmental problem, disability or handicapping condition in N:

(i) .....

(ii) .....

(iii) .....

(iv) .....

Comments, e.g. Notes unclear, extra information, etc.

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11. Is there any period in N's life for which it is known that either main H.V. records or C.H.C. records have been destroyed or lost or are unobtainable for any other reason, resulting in the present H.V. or C.H.C. records being incomplete for that period of N's life?

VAR5568 VAR5572

	H.V. records	C.H.C. records
No — no records known to be missing	1	1
Yes —		
records known missing for part of N's life	2	2
records known missing for all of N's life	3	3
Other answer, specify	4	4

32—35

36—39

If **2 or 3 ringed** in either column, give further details below.

(a) Approximate time period to which missing records relate. Please give dates.

From VAR5569 VAR5573

To VAR5570 VAR5574

40—43

(b) Please give reason why record(s) not available.

VAR5571 VAR5575

Destroyed, lost, etc., i.e. no longer exists	1	1
Record(s) elsewhere or in transit, i.e. exists but not available	2	2
Other reason, specify	3	3
Reason not known	0	0

44—47

Comments, e.g. Extra information etc.

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12. Have any of the following records been used for the completion of this schedule?

Ring all that apply

VAR5576

- Records of any developmental screening in G.P.'s surgery/health centre ... 1
- Handicap record(s), e.g. 2 HP, 4 HP, specify ... 2
- Medical records of nursery school/class or infant school ... 3
- Medical records of day nursery or other day-care ... 4
- Medical records of residential nursery or other residential care ... 5
- Other record(s) or source(s) of information, namely 6

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48,49

Comments, e.g. Notes unclear, records absent, extra information, etc.

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50—53

Name(s) of person(s) completing this Schedule .....

Professional status VAR5577

54—57

Employing Area Health Authority/Health Board VAR5578

Date of completion of Schedule VAR5579 ..../..../ 1975.

58—61

Please use this page to give further details of any questions if insufficient space in the questionnaire.

Please write in your own words a short account of the impression you have gained from the records of this child's health and health care in the first five years and also whether there are any environmental, social or family factors which you consider to be important.

THANK YOU VERY MUCH FOR ALL YOUR HELP