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Measure: Early Development and Home Background (EDHB) Form—Parent/Guardian

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Early Development and Home Background (EDHB) Form—Parent/Guardian

Child's Name: _____

Age: _____

Date: _____

Instructions to Parent or Guardian: Questions P1-P19 ask about the early development and early and current home experiences of your child. Some questions require that you think as far back as to the birth of your child. Your response to these questions will help your child's clinician better understand and care for your child. Answer each question to the best of your knowledge or memory.

What is your relationship with the child receiving care? _____

Please choose one response (✓ or x) for each question.				
Early Development		No	Yes	Can't Remember
P1.	Was he/she born before he/she was due (premature)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P2.	Were the doctors worried about his/her medical condition immediately after he/she was born?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P3.	Did he/she have to spend any time in a neonatal intensive care unit (NICU)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P4.	Could he/she walk on his/her own by the age of 18 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P5.	Has he/she ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P6.	Did he/she ever lose consciousness for more than a few minutes after an accident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early Communication				
P7.	By the time he/she was age 2, could he/she put several words together when speaking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P8.	Could people who didn't know him/her understand his/her speech by the time he/she reached age 4?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P9.	Have you ever been concerned about his/her hearing or eyesight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P10.	By the time he/she was age 4, was he/she interested in playing with or being with other children?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Environment				
P11.	Was there ever a time when he/she could not live at home and someone else had to look after him/her?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
P12.	Has he/she ever been admitted to the hospital for a serious illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P13.	Does anyone at home suffer from a serious health problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P14.	Does anyone at home have a problem with depression?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P15.	Does anyone at home regularly see a counselor, therapist, or other mental health professional?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P16.	Does anyone at home have a problem with alcohol, drugs, or other substances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P17.	Would you say that the atmosphere at home is usually pretty calm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Less Than Once a Month	Between Once a Week and Once a Month	More Than Once a Week
P18.	How often are there fights or arguments between people at home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P19.	How often does your child get criticized to his/her face by other family members when he/she is at home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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