Medical & Developmental History

Date:____________

Child's name:______________________________________ Date of Birth:________________ Age:_____

Parent Contact: ____________________________________ Primary phone:__________________________

Information concerning the patient or his/her family contained herein or hereafter obtained is confidential and will not be disclosed except as is necessary to provide medical care and related service to the patient.

1. Describe or list your concern:
____
____

2. When were you first aware of this issue?
____

3. Has this child had previous evaluations for this concern? If so, list practitioners/providers.
____

4. What treatments and/or medications have been tried?
____

5. What would you like to accomplish at this evaluation?
____

6. Any history of speech or language difficulties in the immediate or extended family? If yes, relationship to child?
____

7. Any history of hearing loss or impairment in the immediate or extended family? If yes, relationship to child?
____

Pregnancy & Birth History

Was this child adopted?________ If so, at what age? _____ Additional details:____________________________________
____

Prenatal care started during the _____month of pregnancy.

During pregnancy did the mother have:	YES	NO	IF YES, PLEASE EXPLAIN
Any problems, illnesses or medications?			
Any complications of labor or delivery?			
Was the baby more than 2 weeks premature?			
Was the baby more than 2 weeks overdue?			
Did the baby have any problems at birth, require treatment or a longer than usual stay?			

How long was the child hospitalized after birth? ____________________What was the baby's birth weight? _______________

Any other pertinent pregnancy or birth history from above or other:

____

____

In first 6 months	Yes	No	IF YES, PLEASE EXPLAIN	Speech & Language Development	Yes	No	IF YES, PLEASE EXPLAIN
Baby was difficult to feed				Delayed in speech			
Baby gained poorly				Began speaking later than expected?			
Serious illness/complications				Voice sounds strained or raspy?			
				Difficult to understand?			
REVIEW OF SYSTEMS	**Yes**	**No**	**Don't know**	Says sounds incorrectly?			
Eyes, ears, nose & throat				Child is often irritable?			
Concerns re: vision or eyes?				Has frequent tantrums?			
Wears glasses?				Frequently seems overactive?			
Concerns re: hearing?				Seems immature in one or more areas? List areas if so:			
Wears hearing aid?				Shows age-expected play skills with other children?			
Frequent ear infections?							
Hearing Tested? ___________________ If yes, when and what was the recommendation or outcome? ____ ___ Receives mental health services (explain)							
				Child has unusual behavior			

In first 6 months	**Yes**	**No**	**IF YES, PLEASE EXPLAIN**	**Speech & Language Development**	**Yes**	**No**	**IF YES, PLEASE EXPLAIN**
Dental problems				Has been separated from parents by hospitalization, death or divorce (explain)			
Trouble chewing or swallowing				Other concerns (explain)			
Choking or gagging with feeding							
Frequent sore throats/tonsillitis				**Early Development** *Leave blank if you don't know or don't remember*	**Age** Yrs	Mos	**Hasn't Yet**
Other concerns (explain)				Rolled self over			
Respiratory				Was able to sit without support			
Chronic cough				Learned to crawl			
Gastro/intestinal				Walked independently			
Frequently has abdominal pain				Learned to ride tricycle			
Appetite is poor				Pointed to indicate wants			
Spits up frequently after eating				Used first words other than "mama" and "dada"			
Has spells of vomiting				Used sentences			
Frequently constipated				Toilet trained			
Has recurrent diarrhea				Became dry at night			
Like to eat strange things: dirt, paint					**Yes**	**No**	**Don't know**
Other concerns (explain)				Able to use spoon without spilling			
Activities of Daily Living							
Muscles				Able to drink from cup without spilling			
Slow to walk/delayed in motor skills				Puts on shirt & pants without help			
Stumbles & falls frequently				Uses toilet independently			
Nervous System				Takes bath or shower independently			
Frequent headaches				Any loss of skills? (explain)			
Convulsions, seizures, epilepsy							

In first 6 months	Yes	No	IF YES, PLEASE EXPLAIN				
Serious Head Injury?				Any serious, unusual, prolonged or repeated illnesses?			
Birth defects?							
Other concerns (explain)							
Sleep							
Loud snoring							
Slow to fall asleep							

Nighttime awakenings		**Name of Hospital**	**City & State**
Hospitalization & Surgical Procedures	**Date**		
Reason for Hospitalization			
Name of Surgical Procedure			
		Allergies to Medications, Foods & Other Things	
Serious Injuries & Illnesses (explain):	**Date**		

Immunizations: (Circle one) Up-to-date Elected to not immunize
Any reactions to immunizations?

Current medications, diet & health procedures:
List ALL medications, prescribed or non-prescribed, including vitamin/supplements:
____
____

Is child on a special diet (explain):
____
____

Child's favorite or most frequently preferred foods?
____
____

Is the child on special feeding program (explain):
____
____

Other special health procedures (explain):
____
____

Child Care & Education
Does child participate in child care? ____ If yes, name, location & phone number of contact person:______________________________
Does child participate in an Early Intervention or Special Education program? If yes, name & location of contact person:______________________________
Name of current school or preschool (if any): ______________________________ Location: ______________________________

Does child receive special help/support services at school? (circle all that apply)

Special Class   Learning center/resource room   Speech   Occupational Therapy   Physical Therapy

Behavioral Plan   Other (specify)______________________________

Has your child been held back/repeated a grade? (circle one) Yes No

What is your estimate of your child's academic performance:	Well Below Grade Level	Slightly Below Grade Level	At Grade Level	Slightly Above Grade Level	Well Above Grade Level
Math					
Reading					
Written Language					
Spelling					

Please list any other therapists/Doctors working with your child (name & contact information):
____
____
____
____

May we request & share information with these past & current providers?
(PLEASE INITIAL IF OK): _______

(Please provide us with records of previous evaluations where possible)

CURRENT DEVELOPMENTAL CHARACTERISTICS:

Please list the child's strengths (for example: personality, activities, makes friends easily, etc.)
____
____

Please list the child's areas of need as you see them/list challenges your child experiences:
____
____

FAMILY HISTORY – List child's immediate family members (parents, brothers, sisters)
Circle if not currently living with child.

Name	Age	Medical Illnesses
1. Mother		
2. Father		
3. Siblings		
4.		
5.		
6.		
List other current household members:		
1.		
2.		
3.		