



Dear Parent/Guardian:

Please answer the following questions as best as you can, and bring this form in with you on the day of your appointment. If you have any questions about a specific item of information being asked, you can call before your appointment as the information will be covered during the appointment.

If you have a young child, please bring some favorite toys to play with.

Thank You.

Name of Child: _____ **Date of Birth:** _____

Are you concerned about how your child:

behaves develops learns uses language pays attention

MEDICATIONS

Currently takes: _____

Taken in the past: _____

ALLERGIES

Does your child have known allergies to food or medication? Yes No

BIRTH HISTORY

Child's weight at birth: _____ lbs. _____ oz.

Was your child born full term? Yes No If not, at what week of gestation? _____ weeks

What type of delivery did you have?

Vaginal delivery: normal/spontaneous Pitocin-induced

Cesarean Section: If so, was this due to repeat fetal distress

How old was the mother at the time of delivery? _____ years

What number pregnancy was this (for example 1st, 2nd, etc.)? _____

What number delivery was this (for example 1st, 2nd, etc.)? _____

Were there any maternal medical problems during the pregnancy? Yes No

If yes, what was/ were the problem(s)? _____

Were there any medications taken during the pregnancy? Yes No

If yes, what medication(s) and why? _____

Was your child in the NICU? Yes No

If yes, for how long and why? _____

FAMILY & SOCIAL HISTORY

Family Composition

Who lives at home? _____

Mother's highest grade completed __ Occupation _____

Father's highest grade completed __ Occupation _____

Please list all other brothers and sisters of child:

Name	Age	Gender
		<input type="checkbox"/> Male <input type="checkbox"/> Female
		<input type="checkbox"/> Male <input type="checkbox"/> Female
		<input type="checkbox"/> Male <input type="checkbox"/> Female
		<input type="checkbox"/> Male <input type="checkbox"/> Female
		<input type="checkbox"/> Male <input type="checkbox"/> Female

Do any other members of the family have problems with attention, behavior, learning, using language, have developmental disabilities including autism, or died from a heart condition prior to the age of 50? Yes No

If yes, please explain: _____

SLEEP HISTORY

Child usually goes to sleep at ____PM

Does your child fall asleep independently? Yes No

How long does it take to fall asleep? _____

Does your child sleep through the night? Yes No

Child gets up is wakened at ____AM

Does your child snore – 2 or more times a week? Yes No

Does your child maintain a stable bedtime and wake time seven days a week? Yes No

MEDICAL HISTORY

Are your child's immunizations up to date? Yes No

Please list any/all operations, hospitalizations (including Emergency Room visits), and procedures your child has had:

Where	When	Why

When was your child's last vision screening or evaluation? _____ Normal Other _____
 hearing screening or evaluation? _____ Normal Other _____

Did/does your child have frequent ear infections? Yes No

Does your child have

- Poor growth? Yes No
- Heart problem? Yes No
- Asthma or other respiratory problems? Yes No
- Stomach or bowel problems? Yes No
- Urine problems? Yes No
- Motor weakness or coordination problems? Yes No
- Headaches? Yes No
- Seizures? Yes No
- Anemia or other blood disease? Yes No

If you answered 'Yes' to any of questions above, or if your child has any other health care problem/s that are not listed, please explain:

DEVELOPMENTAL HISTORY

Please list age at which your child:

Sat up _____ Walked alone _____

Said 'Mama' & 'Dada' _____ Spoke in single words _____

Spoke in 2-word phrases _____ Spoke in few-word phrases _____

Speech understood by strangers _____

School & Services

Name of School _____ District _____

Are any of the following therapies being currently provided?

- Physical Therapy
- Occupational Therapy
- Counseling
- Speech Therapy
- Resource Room
- Other: _____

Has your child ever had any evaluations such as audiology, psychology, or speech/language?

PLEASE BRING A **PHOTOCOPY** OF EACH EVALUATION WHICH YOU WILL LEAVE IN THE OFFICE. Our office staff will not be able to make copies for you.

Describe peer interactions (interactions with same age children who are not siblings):

For children 4 years and older:

Would you say that your child displays the following behaviors?

- 1. Is "on the go" or "driven by a motor" Yes No
- 2. Has difficulty engaging in quiet activities Yes No
- 3. Fidgets or squirms Yes No
- 4. Has difficulty staying seated Yes No
- 5. Restlessness Yes No
- 6. Runs about and excessively and inappropriately Yes No
- 7. Talks excessively Yes No
- 8. Blurts out answers before questions completed Yes No
- 9. Has difficulty awaiting his or her turn Yes No
- 10. Interrupts or intrudes on others Yes No
- 11. Avoids tasks which require sustained mental effort Yes No
- 12. Has difficulty organizing tasks and activities Yes No
- 13. Has difficulty sustaining attention Yes No
- 14. Does not seem to listen Yes No
- 15. Is easily distracted Yes No
- 16. Is forgetful in daily activities Yes No
- 17. Loses necessary items such as school books and materials Yes No
- 18. Has difficulty following through on instructions from others Yes No