ALBUQUERQUE
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PEDIATRIC HISTORY FORM (for Parent/Guardian to complete before appointment)

The following questions are being asked to help us better understand your child. Please fill out this form before your child's appointment, and bring it with you on the day of the appointment. Please read the questions carefully and answer them as fully as possible.

Are there parts of this form that **should not be** discussed in front of your child? ☐**Yes** ☐**No**

Date form was completed: ________________________

Name of person filling out form: __________________ Your relationship to child: ____________ Phone #: ______________

CHILD'S INFORMATION:

Child's name:________________________________ Age: ____ Date of Birth:_________ Sex: ☐M ☐F ☐Other

Mailing Address: ____

City: ___________________________ State: ________ Zip: _____________ Home Phone #:_________________

This child is: ☐Right- handed ☐Left-handed ☐Unsure

Has this child been tested in the last 12 months (for example, for special education, speech and language, or developmental issues)? ☐No ☐Yes

REFERRAL INFORMATION:

Please describe as fully as you can why this child is being brought for evaluation. If he/she has a medical condition that may be contributing to his/her problems (e.g., head injury, seizures, brain tumor), please include what happened, when it happened, type of treatment provided, etc.

____

____

____

FAMILY INFORMATION:

	Birth Mother	Birth Father
Name:	____________________	____________________
Age:	____________________	____________________
Highest grade finished:	____________________	____________________
Current Job:	____________________	____________________
Home Address:	____________________	____________________
Phone Number:	____________________	____________________

Status of parents' relationship: ☐Married ☐Separated ☐Divorced ☐Never married ☐One or both parents died

With whom does the child live?

____

CULTURE/BACKGROUND/IDENTITY:

	Child	Birth Mother	Birth Father
Ethnicity			
1. Hispanic or Latino	☐	☐	☐
2. Not Hispanic or Latino	☐	☐	☐
3. Unknown	☐	☐	☐
Race			
a. African-American or Black	☐	☐	☐
b. Asian	☐	☐	☐
c. White	☐	☐	☐
d. Native American or Alaskan Native	☐	☐	☐
e. Native Hawaiian or Pacific Islander	☐	☐	☐
f. Other: _______________	☐	☐	☐
f. Unknown	☐	☐	☐

What is the **main language** spoken in the home? ☐English ☐Spanish Other:______________________________

Does **this child** speak a language other than English? ☐No ☐Yes

If yes, what language(s)?___________________ At what age did this child start speaking this language?_____________

CHILD/FAMILY HISTORY

Please indicate if the child or any immediate family members (siblings, parents, or grandparents) have or have had any of the following:

	Child	**Family Member (check box** and write **which family member** next to it)
Psychiatric problems		
Anxiety or phobias	☐	☐
Depression	☐	☐
Bipolar disorder (manic-depression)	☐	☐
Schizophrenia	☐	☐
Suicide	☐	☐
Alcoholism	☐	☐
Drug abuse	☐	☐
Neurodevelopmental problems		
Autism spectrum disorder	☐	☐
Attention deficit disorder/hyperactivity (ADHD)	☐	☐
Learning disability (reading, writing, math)	☐	☐
Intellectual disability (mental retardation)	☐	☐
Language or Speech problem	☐	☐
Medical/Neurological problems		
Cerebral palsy	☐	☐
Epilepsy (seizures, convulsions)	☐	☐
Genetic Disorders	☐	☐
Stroke	☐	☐
Cancer	☐	☐

PREGNANCY AND DELIVERY:

Mother's age at pregnancy of this child: _______________ Father's age at pregnancy of this child: _________________

When did prenatal care begin with this child? ____

Mother's health during the pregnancy: ☐Excellent ☐Fair ☐Poor

Please check any of the following that the child's **mother** had during the pregnancy:

☐Measles ☐Excessive swelling ☐Emotional problems
☐German measles ☐Excessive vomiting ☐Injury or accident
☐High fever ☐Poor nutrition ☐Placenta abrupta
☐High blood pressure ☐Abnormal weight gain ☐Placenta previa
☐Toxemia/Pre-eclampsia ☐Diabetes ☐X-rays (in what month? _________)
☐**Other medical conditions mother experienced during pregnancy**:____

☐**Hospitalizations/surgeries during pregnancy** If yes, please describe: ____________________________________

☐**Took medications during pregnancy** If yes, please describe ____

Substances used during pregnancy:	**Amount/Frequency:**	**Trimester of pregnancy used:**
☐Cigarettes	_____ per (☐day ☐week ☐month)	☐ 1st ☐ 2nd ☐3rd
☐Alcohol	_____ per (☐day ☐week ☐month)	☐ 1st ☐ 2nd ☐3rd
☐Other Drugs:__________________________	_____ per (☐day ☐week ☐month)	☐ 1st ☐ 2nd ☐3rd
☐None		

This child was born: ☐On time ☐Early ☐Late Length of pregnancy: ______ weeks
Type of labor: ☐Spontaneous ☐Induced Length of labor: ______ hours

Type of **delivery**: ☐Head first ☐Breech ☐C-section ☐Forceps/suction used
☐Cord around neck ☐Cord presented first ☐Hemorrhage ☐Infant injured during pregnancy
☐Other (describe) ____

Child's **birth weight**: ____________ Length of stay in hospital for Mother: ______ days
for Child: ______ days

Check any of the following that **this child** had at birth or during the first week of life:
☐Difficulty breathing (If so, describe____)
☐Supplemental oxygen (If so, how long?________________________)
☐Seizures/convulsions ☐Feeding problems ☐Excess vomiting ☐Fever
☐Jaundice ☐Bilirubin lights used ☐Drugs/medications needed
☐Other complications (describe): ____

DEVELOPMENTAL HISTORY

Check all that applied to this child **when he/she was an infant or toddler**:
☐Overly active ☐Colicky ☐Hard to please ☐Cried more than other infants/toddlers
☐Frequently sick ☐Breathing problems ☐Frequent ear infections ☐Sleeping problems
☐Rocked self a lot ☐Head banging ☐Poor eye contact ☐Rigid about routines/rituals
☐Odd or unusual behaviors/interests ☐Did not smile when others smiled at him/her
☐Uninterested in other children ☐Uninterested in social games (e.g., peekaboo)
☐Other problems (describe here):_______________________________________

Give approximate ages when this child did the following:

Large Movements	Small Movements
Sat without support ______________________	Picked up small objects _________________
Crawled/crept ________________________	Fed him/herself _______________________
Stood without help______________________	Held a crayon ________________________
Walked alone _________________________	

Language	Toileting
Said "mama or dada" ______________________	Bladder trained ______________________
Spoke first words _______________________	Bowel trained ________________________
Talked in 2-3 word phrases _____________	
Talked in full sentences __________________	

Did this child have any of these intervention services **between the ages of 0-3 years**?

Speech-language therapy? ☐No ☐Yes

Occupational therapy? ☐No ☐Yes

Physical therapy? ☐No ☐Yes

MEDICAL HISTORY

Please check if this child has had any of the following and write at what ages they occurred:

☐ Head injury/concussion	age:_________	☐ Appetite/weight problems	age:_________
☐ Seizures/convulsions	age:_________	☐ Sleep problems	age:_________
☐ Meningitis or encephalitis	age:_________	☐ Vision problems	age:_________
☐ Stroke	age:_________	☐ Hearing problems	age:_________
☐ Cancer	age:_________	☐ Heart problems/hypertension	age:_________
☐ Diabetes	age:_________	☐ Chronic Kidney Disease	age:_________
☐ Asthma	age:_________	☐ Headaches/migraines	age:_________
☐ COVID-19	age:_________	☐ Poisoning	age:_________

☐ Allergies (please list: ____) age:_________

Please describe any other **serious illnesses, injuries, operations, or inpatient hospitalizations** that this child has had: age:

____ _________

____ _________

____ _________

Medications this child is taking **currently**:

Name of medicine	Dose (How much):	Frequency (How often):	Prescribed by (Name of provider):
___________________________	_______________	____________________	________________________
___________________________	_______________	____________________	________________________
___________________________	_______________	____________________	________________________

Who is this child's primary care **physician**? ____

Has this child had a recent **vision** exam? ☐No ☐Yes Does the child wear glasses/contacts? ☐No ☐Yes

Has this child had a recent **hearing** check? ☐No ☐Yes Does the child use hearing aids? ☐No ☐Yes

Has this child ever had a **neurological exam**? ☐No ☐Yes, with the following result:_______________________

____

Has this child ever had an **EEG**? ☐No ☐Yes, with the following result_____________________________________

Has this child ever had an **MRI** or **CT**? ☐No ☐Yes, with the following result_________________________________

PSYCHIATRIC HISTORY

Has this child ever received a **mental health diagnosis** from a medical provider (e.g., major depressive disorder, generalized anxiety disorder, adjustment disorder, ADHD, autism spectrum disorder)?

☐No ☐Yes If yes, list diagnoses:

____

____

Has this child ever received **other mental health treatment**, such as working with a psychiatrist for medication or going to the hospital for an emergency mental health issue?

☐No ☐Yes If yes, list name of provider(s), when this child was treated, and type of treatments:

____

____

Has this child ever received **counseling** (either individually or with the family)?

☐No ☐Yes If yes, list name of counselor(s), when this child was treated, and type of treatments:

____

____

Has **Children, Youth, and Families Department (CYFD)** or any other Child Protective Services (CPS) agency **ever been involved** with this child or others in the home? ☐No ☐Yes If yes, please explain:_______________________________

____

Has this child had any unusual, **traumatic** or possibly **stressful events** that you think may have had an impact on his/her development and current functioning ☐No ☐Yes ? If yes, please describe the event(s). Include the child's age at the time of the event(s). ____

SCHOOL HISTORY

Has this child received a **Child Find** evaluation? ☐No ☐Yes If yes, what were the results?: ______________________

____

Did this child receive **intervention services** in preschool? ☐No ☐Yes If yes, please describe: _____________________

____

What **school** is this child going to now?____

What **grade** is this child in (e.g., preschool, kindergarten, 1st, 2nd, etc.)? _______

Total **number of schools** this child has attended: ________

Has this child ever **repeated** a grade? ☐No ☐Yes If yes, which grade(s)____________________________

Has this child **skipped** a grade in school? ☐No ☐Yes If yes, which grade(s) ____________________________

Does or did this child have any trouble with **math**? ☐No ☐Yes If yes, explain: ____________________________

____

Does or did this child have any trouble with **reading**? ☐No ☐Yes If yes, explain:___________________________

____

Does or did this child have any trouble with **spelling or writing**? ☐No ☐Yes If yes, explain:__________________

____

This child's classroom instruction is in: ☐English only ☐English with Spanish-speaking aide ☐Spanish only ☐Dual language (____% English, ____% Spanish)

This child reads and writes in ☐English only ☐Spanish only ☐English and Spanish ☐Other_____________

Please circle if this child has ever had any of the following:

Individualized Education Program (IEP)	**Current**	**Past**	**Never**
504 Plan	**Current**	**Past**	**Never**
Behavioral Intervention Plan (BIP)	**Current**	**Past**	**Never**
Student Assistance Team (SAT) Intervention Plan	**Current**	**Past**	**Never**

If yes, what is (or what was) the main reason? Check below:

☐Specific Learning Disability
☐Speech or Language Impairment
☐Other Health Impairment
☐Gifted
☐Multiple Disabilities
☐Intellectual Disability
☐Autism
☐Developmental Delay
☐Vision Impairment
☐Traumatic Brain Injury
☐Emotional Disturbance
☐Orthopedic Impairment
☐Hearing Impairment

Please circle if this child has ever received any of the following special education services **in school**:

Speech-language therapy	**Current**	**Past**	**Never**
Occupational therapy	**Current**	**Past**	**Never**
Other: _______________	**Current**	**Past**	**Never**
Social Work/counseling	**Current**	**Past**	**Never**
Physical therapy	**Current**	**Past**	**Never**

Does this child get special education services **right now**? ☐No ☐Yes If yes, in which of the following settings:

☐**Inclusion** setting services only (i.e., all special education provided in regular education classroom)

☐**Segregated** services primarily (i.e., most academic coursework provided in segregated/special education classroom)

☐**Mixed** settings (i.e., some classes in regular education classroom and in segregated/special education classroom)

If **Mixed**, Please list child's classes taught in **Inclusion** setting: ____

Please list child's classes taught in **Segregated** setting: ____

Please check below if this child ever received any of the following testing:

☐School/Psycho-educational Evaluation ☐Psychological Evaluation ☐Autism Evaluation

☐Neuropsychological Evaluation ☐Speech/Language Evaluation ☐Occupational Therapy Evaluation

☐Physical Therapy Evaluation

If this child has ever received any of these types of testing, please attach the records/report from the evaluation(s).