Date: _____/_____/_____

PEDIATRIC MEDICAL AND SOCIAL HISTORY FORM

Caregivers, please complete to the best of your knowledge.

DEMOGRAPHIC INFORMATION:

Child's Full Name: _____ DOB: _____/_____/_____

Child's Gender: _____ Child's Race/Ethnicity: _____

Religious Affiliation: _____ Primary Language: _____

Any other languages spoken at home: _____ ☐ N/A

Caregiver #1 Name: _____ Phone Number: _____

Relationship: ☐ Biological Parent ☐ Adopted Parent ☐ Foster Parent ☐ Step Parent ☐ Other: _____
Is this caregiver a legal guardian? ☐ Yes ☐ No

Caregiver #1 Email Address: _____ Occupation: _____

Caregiver #2 Name: _____ Phone Number: _____

Relationship: ☐ Biological Parent ☐ Adopted Parent ☐ Foster Parent ☐ Step Parent ☐ Other: _____
Is this caregiver a legal guardian? ☐ Yes ☐ No

Caregiver #2 Email Address: _____ Occupation: _____

Other Caregivers Involved (stepparents, etc.): _____

CHILD'S CURRENT CARE PROVIDERS:

Physician Name	**Specialty** (PCP, Cardiologist, Gastroenterologist, Psychiatrist, etc.)
	Pediatrician/Primary Care Physician

MEDICATIONS: *Please list all current prescription medications, vitamins, or supplements (including melatonin).* **OR** ☐ **My child takes no medications.**

Medication Name	**Dosage**	**Approximate Start Date**	**Prescriber**

ALLERGIES: *List all allergies to medications, foods, or other agents.* **OR** ☐ **My child has no known allergies.**

Allergy	**Reaction**

MEDICAL HISTORY: *Please indicate (X or ✓) whether the child or any family members have had any of the following concerns.*

	Child currently has	Child currently takes medication for	Child has had in the past	Runs in mother's side of family	Runs in father's side of family
Asthma					
Anemia					
Heart disease					
Stroke					
Diabetes					
High blood pressure					
Cancer					
Epilepsy					
Autoimmune disorders					
Chronic pain					
HIV/AIDS					
ADHD					
Autism					
Anxiety					
Depression					
Bipolar Disorder					
Schizophrenia					
Alcohol Abuse					
Drug Abuse					
PTSD					
Suicide					

Any other medical conditions or concerns:

_____

_____

Has this child ever received counseling or therapy services in the past?

☐ Yes (please list dates and reasons for services below) ☐ No ☐ Unknown

_____

How would you rate the child's overall health?

☐ Poor ☐ Average ☐ Good ☐ Great

How often would you say that the child participates in physical activity?

☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently

Is the child up to date on their immunizations? ☐ Yes ☐ No ☐ Unknown

Has the child had any hospitalizations and/or surgical procedures?

☐ Yes (please explain below) ☐ No ☐ Unknown

_____

Has the child had any history of head injuries (i.e., concussions, loss of consciousness, etc.)

☐ Yes (please explain below) ☐ No ☐ Unknown

_____

Does the child have any concerns or conditions related to vision?

☐ Yes (please explain below) ☐ No ☐ Unknown ☐ Suspected

_____

Does the child have any concerns or conditions related to hearing?

☐ Yes (please explain below) ☐ No ☐ Unknown ☐ Suspected

_____

Does the child have any concerns or conditions related to speech?

☐ Yes (please explain below) ☐ No ☐ Unknown ☐ Suspected

_____

Does the child have any concerns or conditions related to weight and/or eating?

☐ Yes (please explain below) ☐ No ☐ Unknown ☐ Suspected

_____

Does the child have any concerns or conditions related to dental care/teeth?

☐ Yes (please explain below) ☐ No ☐ Unknown ☐ Suspected

_____

Does the child currently have any other services in place (speech therapy, occupational therapy, physical therapy, ABA services, etc.)?

☐ Yes (please explain below) ☐ No ☐ In the process of arranging

_____

BIRTH AND EARLY DEVELOPMENT:

Were there any medical problems during pregnancy?

☐ Yes (please check/explain below) ☐ No ☐ Unknown ☐ Suspected

☐ *High blood pressure* ☐ *Trauma* ☐ *Toxemia* ☐ *Depression/Anxiety*
☐ *Anemia* ☐ *Weight concerns* ☐ *Infection* ☐ *Placental concerns*
☐ *Gestational diabetes* ☐ *Excessive Vomiting* ☐ *Preeclampsia*
☐ *Other:* _____

Were cigarettes, alcohol, or other drugs used during pregnancy?

☐ Yes (please explain below) ☐ No ☐ Unknown ☐ Suspected

_____

Were there any problems during labor and delivery?

☐ Yes (please check/explain below) ☐ No ☐ Unknown ☐ Suspected

☐ *Breech birth* ☐ *Cord around neck* ☐ *Labor induced* ☐ *Forceps used*
☐ *Other:* _____

Were there any problems such as needing oxygen, trouble breathing, jaundice (yellowness), etc. after the baby's birth?

☐ Yes (please explain below) ☐ No ☐ Unknown ☐ Suspected

_____

Did the child have to spend any time in the NICU after birth?

☐ Yes (please explain below) ☐ No ☐ Unknown ☐ Suspected

_____

Method of Delivery: ☐ Vaginal ☐ Scheduled Caesarean ☐ Emergency Caesarean Child born prematurely? ☐ Yes ☐ No

Length of Pregnancy: _____ weeks Birth Weight: _____ lbs. _____ oz.

Did mother experience any postpartum depression? ☐ Yes ☐ No ☐ Unknown ☐ Suspected

Were there any concerns about growth or progress made in developmental milestones such as rolling over, crawling, walking, talking, potty training, etc.?

☐ Yes (please explain below) ☐ No ☐ Unknown ☐ Suspected

_____

HOME ENVIRONMENT:

Has there been a time in which the child had to be separated from parents and cared for/looked after by another caregiver for a significant period of time (such as foster care, or when a caregiver was incarcerated or receiving long term medical care)?

☐ Yes (please explain below) ☐ No

_____

Has the Department of Child and Family Services or Child Protective Services ever been involved with your family?

☐ Yes (please explain below) ☐ No

_____

Is there currently a formal custody arrangement involving your child?

☐ Yes (please explain below) ☐ No

_____

**Please note that we must have a copy of formal custody agreement on file if applicable to continue treatment.*

If applicable, status of parents' relationship: ☐ Married ☐ Together ☐ Separated ☐ Divorced ☐ Never Married ☐ Never Together

If divorced/separated, child's age at time of divorce/separation: _____

Please list the people who currently live in your home:
Primary Household: Child spends _____% of the time here.

Name	Age	Relationship to Child

Secondary Household (if applicable): Child spends _____% of the time here.

Name	Age	Relationship to Child

EDUCATION:

Is the child currently in a school or daycare setting? ☐ Yes ☐ No Child's grade in school: _____

Name of child's school/daycare: _____

Child's grades generally are: ☐ A ☐ B ☐ C ☐ D ☐ Failing ☐ N/A (child in a setting that doesn't give grades)

Child's placement: ☐ Regular Education ☐ Resource ☐ Special Education ☐ Other: _____

Describe the child's current educational setting: ☐ None of the below apply

☐ Gifted/Talented ☐ Behavior Plan ☐ Speech therapy

☐ Occupational therapy ☐ Physical therapy ☐ Social work/counseling services

☐ 504 Plan (if so, please describe what for: _____)

☐ IEP (if so, please describe what for: _____)

Has this child ever skipped a grade? ☐ No ☐ Yes (if so, please describe: _____)

Has this child ever repeated a grade? ☐ No ☐ Yes (if so, please describe: _____)

Has this child ever been expelled from a school? ☐ No ☐ Yes (if so, please describe: _____)

Does the child have any learning disabilities?

☐ Yes (please explain below) ☐ No ☐ Unknown ☐ Suspected

_____

Have teachers conveyed any concerns about this child's academic, behavioral, or social performance?

☐ Yes (please explain below) ☐ No

_____

Any other concerns with the child's academic setting or performance:

_____

_____

_____