140 S Beach Street, Suite 310 Daytona Beach FL 32114
Email: assistant@thehopegroup4.com P.386.898.6040 F.386.256.2320

Basic History

Is the Patient your: _____ (biological child, adoptive child, foster child)

Was this a normal pregnancy: yes ☐ no ☐ unknown ☐ If no please explain _____

_____

_____

Was the birth: Vaginal ☐C-Section ☐Unknown ☐Birth weight Length of Pregnancy

Complication during childbirth: yes ☐ no ☐ unknown ☐ If yes please explain _____

_____

Did your Child feed well after birth? yes ☐ no ☐unknown ☐ If yes please explain _____

_____

Medical History

Please check any of the following your child had/has and indicate the age of onset
Please indicate if your child has ever had any of the following:

☐ Problems with vision	☐ Unusual reaction(s) to immunization	☐ Heart Problems
☐ Problems with hearing	☐Seizures, convulsions or staring spells	☐ Too fast heartbeat or chest pain
☐ Serious infections/illness	☐ Head injury/lost consciousness	☐ Problems with vomiting, diarrhea, or constipation
☐ Serious injury/burn/ broken bones	☐ Frequent headaches/migraines	☐ Frequent stomachaches
☐Poisoning or exposure to toxic chemicals (e.g., lead)	☐ Fainting spells/dizziness	☐ Problems with kidney, bladder, or urine
☐ Hospitalizations or surgeries	☐ Problems with restless sleep or snoring	☐ Blood problems or anemia
☐ Frequent accidents/injuries	☐ Serious nose, mouth, or throat problems	☐ History or suspicion of physical or sexual abuse
☐ Serious/chronic health problem (e.g., diabetes)	☐ Serious ear infections or ear tubes	☐ History or suspicion of tobacco, alcohol, or drug use
☐ Over eats or overweight	☐ Motor tics (blinking, squinting, head tossing)	☐ If female, has gotten her period
☐ Small for age or underweight	☐ Vocal tics (grunting, throat clearing)	☐ Thyroid or hormone problems
☐ Difficulties with eating, diet, or appetite	☐Breathing or lung problems	☐ Problems with gait (the way s/he walks)
☐ Birth defect or birth marks	☐ Compulsive behaviors	☐ Mental health problems

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Has your child ever been hospitalized? yes ☐ no ☐unknown ☐ If yes please explain _____

_____

List any serious accidents your child may have been involved please include injurie(s) and date(s) _____

_____

Is there any history of medical, developmental, or learning problem(s) in your family? yes ☐ no ☐unknown ☐

If yes, please explain _____

_____

_____

Does your child have any allergies or sensitives especially to Food? yes ☐ no ☐unknown ☐

If yes, please explain _____

Any additional information you want to share in regard to your child's medical history _____

_____

_____

School History

Does your child attend: Daycare ☐Preschool ☐ Elementary ☐Middle ☐Highschool ☐other _____

Did your child repeat a grade(s) yes ☐ no ☐unknown ☐

If yes, please explain

Is your child attending: General ED ☐Special ED ☐Combination ☐Hospital Homebound ☐Homeschooled ☐

Have any learning problems been identified: yes ☐ no ☐unknown ☐If yes, please explain _____

_____

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Please tell us more about the services your child receives or has received at school:

504 Plan ☐ IEP ☐ IFSP ☐ School Testing (CORE) Evaluation ☐PT ☐OT ☐SP☐ABA ☐Counseling at school ☐

Academic area of concerns _____

_____

_____

Any additional information you want to share in regard to your child's educational history _____

_____

_____

Additional Information