Patient's Name: _____ Date of Birth: _____
Your name and relationship to patient: _____

Patient History

Instructions: Please take a few moments to fill out the following information. This will save us some time during the visit to spend more time addressing your specific concerns. If there is not enough room please feel free to use extra paper.

Who were you referred by: _____

Your child attends: Public School Name and contact person:_____
(circle if applicable) Private School Name and contact person:_____
Home School Coop or curriculum used:_____
Day Care Name:_____

Your primary concerns for your child:

_____
_____

What are your child's strengths?

_____

What is difficult for your child? Academics Behavior Both

_____

Past Medical History:

Who is your child's primary care doctor? _____
Is your child allergic to any medicines or foods? No Yes What: _____
Are your child's immunizations current? No Yes
Is your child on any medications? No Yes What: _____

Birth History: Please explain for any Yes answers

During pregnancy were there any illnesses or hospitalizations?	No	Yes	
Were there any medications taken during the pregnancy?	No	Yes	
Was there use of alcohol or drug including cigarettes during pregnancy: when and how much?	No	Yes	
Was the child premature? How far?	No	Yes	
Were there any complications during delivery?	No	Yes	Delivered by Vaginal or Caesarean
Was the labor prolonged?	No	Yes	
Were there any medications taken during the delivery?	No	Yes	
What was the child's birth weight?			Birth Weight:

Any of the following complications:			Please explain if yes:
Difficulty breathing?	No	Yes	
Required oxygen or breathing tube?	No	Yes	
Congenital defects?	No	Yes	
Low tone?	No	Yes	
Heart problems?	No	Yes	
Poor feeding or vomiting?	No	Yes	
Jaundice? Treated how?	No	Yes	
Physical injuries?	No	Yes	
Eye problems?	No	Yes	
Did your child pass the hearing screen?	No	Yes	

Has your child ever been hospitalized or visited the emergency room? No Yes
If so please explain:

_____

Has your child undergone surgery? No Yes
If so please explain:

_____

Has your child experienced any significant illnesses, injuries, or problems: No Yes
If so please explain (i.e. fractures and/or lacerations):

_____

Please complete the following:

Has your child ever experienced:			If so please explain:
Meningitis?	No	Yes	
Seizures?	No	Yes	
Head trauma with or without loss of conscienceness?	No	Yes	
Visual problems or need glasses?	No	Yes	
Hearing problems?	No	Yes	
Feeding problems?	No	Yes	
Heart Problems?	No	Yes	
Respiratory or lung problems?	No	Yes	
Recurrent vomiting or diarrhea?	No	Yes	
Constipation?	No	Yes	
Wetting accidents?	No	Yes	Daytime Night time or Both
Kidney or Liver problems?	No	Yes	
Muscle problems?	No	Yes	
Skin problems?	No	Yes	
Recurrent infections (more than 5 throat, ear, sinus etc. per year)	No	Yes	
History of anemia?	No	Yes	
History of lead poisoning?	No	Yes	
Sleep problems, snoring, sleep apnea or breathing problems while asleep	No	Yes	

Has your child received any therapies? (PT, OT, Speech, Alternative medicine) No Yes
If so please explain and bring copies of the reports:

_____

_____

Has your child had any previous evaluations for their development or behavior? No Yes
If so please explain and bring copies from private testing or school testing:

_____

_____

Developmental History:

When did your child accomplish the following:		Age
Sit without support	Not yet	
Walk alone	Not yet	
Speak first word	Not yet	
Speak in two word or more sentences (Mommy go, Daddy hold, I want cookie)	Not yet	
Ride a bicycle without training wheels	Not yet	
Tie shoes	Not yet	

Family History:
Is there anyone in the family with similar problems as your child is experiencing?:
Please explain if yes:_____

Does anyone suffer from:			If yes who and what:
Mental Retardation or genetic problems?	No	Yes	
Learning Disabilities?	No	Yes	
Attention problems or ADHD/ADD?	No	Yes	
Substance use or abuse?	No	Yes	
Legal difficulties?	No	Yes	
Emotional or mood problems? (Depression, bipolar, anxiety etc.)	No	Yes	
Cardiac Problems	No	Yes	
Hypertension, Diabetes, Lipid problems, Cholesterol problems	No	Yes	
Other?	No	Yes	

Social History: Has your child experienced any significant stresses? No Yes
If so please explain:

_____

_____

Has the child been on medications for ADHD or behavior previously if so please list:

_____

Any other information you would like me to know about your child:

_____