

Date: \_\_\_/\_\_\_/\_\_\_ Your name: \_\_\_\_\_ Relationship to the child: \_\_\_\_\_

**I. IDENTIFYING INFORMATION**

Child's name: \_\_\_\_\_

Address: \_\_\_\_\_

School/Day Care: \_\_\_\_\_

Grade: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Guardian/Foster Parent: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: M F

Home Phone:(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

School Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Teacher's name: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone/Pager:(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone/Pager:(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone/Pager:(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Parent's marital status: single married separated divorced widowed unknown to informant

All family members	Age	Sex	Grade	Medical Problems

Pediatrician: \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**II. REASON FOR TODAY'S VISIT**

Who referred your child for this evaluation? \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Your description of the problem and reason for today's referral: \_\_\_\_\_

Age of child when problem was first noticed: \_\_\_\_\_ Who else observed this? \_\_\_\_\_

Has your child ever received an evaluation and /or treatment concerning his development?

- Physical Therapy      Hearing      Psychological      Learning      Neurological
- Occupational Therapy   Speech/Language      Behavioral      Psychiatric      Nutritional

If so, where and what were the results? \_\_\_\_\_

What efforts have been made to correct the problem? \_\_\_\_\_

**III. PRE/POSTNATAL HISTORY**

Pregnancy : normal   problems/complications (explain) \_\_\_\_\_

Delivery: vaginal   caesarian   other: \_\_\_\_\_

Birth weight: \_\_\_\_lbs. \_\_\_\_oz.      Premature: no   yes # weeks early: \_\_\_\_\_

Postnatal history: jaundice   required oxygen   cleft lip/palate   other: \_\_\_\_\_

Physical abnormalities: no   yes \_\_\_\_\_

Sucking or swallowing problems: no   yes \_\_\_\_\_

**IV. MEDICAL HISTORY**

General Health: excellent   good   fair   poor      Growth Rate: excellent   good   fair   poor

Which of the following illnesses and/or conditions has your child had?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Head injury                | <input type="checkbox"/> Running ears         |
| <input type="checkbox"/> Chicken pox            | <input type="checkbox"/> Hyperactivity/ADD          | <input type="checkbox"/> Scarlet fever        |
| <input type="checkbox"/> Chronic colds          | <input type="checkbox"/> Influenza                  | <input type="checkbox"/> Sinusitis            |
| <input type="checkbox"/> Chronic ear infections | <input type="checkbox"/> JRA                        | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Convulsions/seizures   | <input type="checkbox"/> Measles                    | <input type="checkbox"/> Tonsillitis          |
| <input type="checkbox"/> Croup                  | <input type="checkbox"/> Meningitis                 | <input type="checkbox"/> Whooping cough       |
| <input type="checkbox"/> Gastric Reflux         | <input type="checkbox"/> Gastro-intestinal problems | <input type="checkbox"/> Heart Problems _____ |
| <input type="checkbox"/> Diphtheria             | <input type="checkbox"/> Mumps                      | <input type="checkbox"/> RSV infection        |
| <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> Pneumonia                  | <input type="checkbox"/> CMV infection        |
| <input type="checkbox"/> Encephalitis           | <input type="checkbox"/> Hepatitis _____            | <input type="checkbox"/> Hearing loss         |
| <input type="checkbox"/> Headaches/migraines    | <input type="checkbox"/> Rheumatic fever            | <input type="checkbox"/> Cerebral Palsy       |
| <input type="checkbox"/> Syndrome: _____        | <input type="checkbox"/> Other: _____               | <input type="checkbox"/> _____                |

Surgery	Age	Surgery	Age
Adenoidectomy			
Tonsillectomy			
Cleft lip/palate repair			

Feeding problems: no   yes \_\_\_\_\_

Allergies:  none   yes (explain) \_\_\_\_\_

Vaccination up to date: yes   no (reason): \_\_\_\_\_

Current medications: \_\_\_\_\_

Musculoskeletal problems:  none   yes (explain) \_\_\_\_\_

Most Recent eye exam: \_\_\_\_/\_\_\_\_/\_\_\_\_   Dr. \_\_\_\_\_   Results: \_\_\_\_\_

Most Recent hearing exam: \_\_\_\_/\_\_\_\_/\_\_\_\_   Results: \_\_\_\_\_

Any medical problems related to eyes or ears?  none   yes (explain) \_\_\_\_\_

Does your child wear glasses: Yes   No      Does your child wears hearing aids? Yes   No

**V. DEVELOPMENTAL MILESTONES**

Motor Skill	Age Achieved	Verbal Skills	Age Achieved
Sit unsupported		Babble and coo	
Crawl		Jargon	
Walk		Meaningful first word	
Toilet trained		Combines 2 or more words	
Dress self		Combines 3 or more words	

**b**

**VI. OTHER CHARACTERISTICS**

How does your child communicate his/her needs?

- cries      gestures      whines      babbles      words

How well is your child understood by others?

- not at all      less than 50%      more than 50%      very well

Does your child have any difficulty with any of the following activities in comparison with peers of same age?

- sports       playground       riding bike       hopping       jumping  
 dressing       coloring       cutting       running       walking  
 buttoning       handling eating utensils       lacing and tying shoes

Describe child's behavior: \_\_\_\_\_

Describe child's relationship with peers: \_\_\_\_\_

Check terms that apply:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Accident prone                         | <input type="checkbox"/> Independent                             | <input type="checkbox"/> Obedient            |
| <input type="checkbox"/> Avoids group play                      | <input type="checkbox"/> Nervous/anxious                         | <input type="checkbox"/> Overly affectionate |
| <input type="checkbox"/> Bites others                           | <input type="checkbox"/> Self-protective                         | <input type="checkbox"/> Isolate play        |
| <input type="checkbox"/> Breaks objects/toys easily             | <input type="checkbox"/> Fearful                                 | <input type="checkbox"/> Shy                 |
| <input type="checkbox"/> Clumsy/awkward                         | <input type="checkbox"/> Friendly                                | <input type="checkbox"/> Sucks thumb/fingers |
| <input type="checkbox"/> Hyperactive                            | <input type="checkbox"/> Happy                                   | <input type="checkbox"/> Tantrums            |
| <input type="checkbox"/> Overly sensitive to touch/sound/smells | <input type="checkbox"/> Touch/handle people/objects excessively | <input type="checkbox"/> Easily frustrated   |

Who does the child communicates with more effectively? \_\_\_\_\_

Is the child a discipline problem?  no     yes    What type of discipline works best? \_\_\_\_\_

**VII. SCHOOL HISTORY**

Age at entrance to school: \_\_ years \_\_ months     preschool     home daycare     kindergarten     other \_\_\_\_\_

Current School: \_\_\_\_\_ Grade: \_\_\_\_ Grades Repeated: \_\_\_\_\_

Type of classroom  regular     special program \_\_\_\_\_  other \_\_\_\_\_

Child's current feelings about school: \_\_\_\_\_

Any reading difficulties noted?  no     yes (explain) \_\_\_\_\_

Any difficulty with completing written work or with writing?  no     yes (explain) \_\_\_\_\_

Is your child currently receiving any special services at school?  no     yes \_\_\_\_\_

**VIII. PLEASE PROVIDE ANY ADDITIONAL HELPFUL INFORMATION**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_