

CHILD HISTORY AND INFORMATION FORM

Please complete this confidential form to help us better understand your child's needs.

Child's Name: _____

Age: _____ Date of Birth: _____ Gender: _____

Do you have any concerns about your child's development? _____

FAMILY INFORMATION

Please check any of the following that are true for this child:

____ was adopted If so, is child aware ____yes ____no
____ is a foster child

Who lives in home with child? (mother, father, stepparent, parent's significant other, brothers and sisters, aunts, uncles, grandparents, foster parents, etc.)

Name	Age	Relation to child

CHILD'S MEDICAL HISTORY

Were there any extraordinary or special circumstances that occurred during the mother's pregnancy? _____

How much did the baby weigh? _____
How long did baby stay in hospital? _____

Please check any of the following, which applied during the first month after birth.

- | | |
|--|---|
| <input type="checkbox"/> 1. breathing problems | <input type="checkbox"/> 9. was given medications |
| <input type="checkbox"/> 2. jaundice (skin yellow) | <input type="checkbox"/> 10. excessive crying |
| <input type="checkbox"/> 3. cyanosis (skin blue) | <input type="checkbox"/> 11. sleeping problems |
| <input type="checkbox"/> 4. convulsions/seizures | <input type="checkbox"/> 12. very inactive |
| <input type="checkbox"/> 5. feeding problems | <input type="checkbox"/> 13. very jittery |
| <input type="checkbox"/> 6. injury | <input type="checkbox"/> 14. stay in intensive care nursery |
| <input type="checkbox"/> 7. physical defect | <input type="checkbox"/> 15. other _____ |
| <input type="checkbox"/> 8. surgery | _____ |

Please check any of the following that the child has had since newborn.

- | | |
|--|---|
| <input type="checkbox"/> 1. recurrent ear infections | <input type="checkbox"/> 13. diabetes |
| <input type="checkbox"/> 2. rashes or skin problems | <input type="checkbox"/> 14. German measles, whooping cough, measles, mumps, or chicken pox |
| <input type="checkbox"/> 3. meningitis &/or encephalitis | <input type="checkbox"/> 15. infections (TB, CMV, HIV) |
| <input type="checkbox"/> 4. headaches &/or migraines | <input type="checkbox"/> 16. genetic or chromosomal testing |
| <input type="checkbox"/> 5. convulsions &/or seizures | <input type="checkbox"/> 17. EEG, MRI, or CT |
| <input type="checkbox"/> 6. head injuries &/or concussions | <input type="checkbox"/> 18. hospitalization |
| <input type="checkbox"/> 7. allergies | <input type="checkbox"/> 19. injury |
| <input type="checkbox"/> 8. eye and/or vision problems | <input type="checkbox"/> 20. surgery |
| <input type="checkbox"/> 9. chronic infection | <input type="checkbox"/> 21. poisoning |
| <input type="checkbox"/> 10. bowel problems | <input type="checkbox"/> 22. other _____ |
| <input type="checkbox"/> 11. slow weight gain | |
| <input type="checkbox"/> 12. heart disease | |

What medications has your child taken or is now taking?

Medication	Dates	Reason	Effectiveness
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DEVELOPMENTAL HISTORY

As closely as you can recall, please write the age when your child did the following:

- | | |
|--|---|
| <input type="checkbox"/> 1. sat up without support | <input type="checkbox"/> 7. spoke first word |
| <input type="checkbox"/> 2. crawled | <input type="checkbox"/> 8. used short sentences |
| <input type="checkbox"/> 3. walked alone | <input type="checkbox"/> 9. toilet-trained (day) |
| <input type="checkbox"/> 4. rode a tricycle | <input type="checkbox"/> 10. toilet-trained (night) |
| <input type="checkbox"/> 5. gave up bottle/breast | <input type="checkbox"/> 11. dressed him/herself |
| <input type="checkbox"/> 6. started solid foods | <input type="checkbox"/> 12. drew a circle |

Do you have any concerns about your child's behavior patterns? _____

Has your child ever been in daycare before? ___yes ___no

School

Dates (or ages) attended

What are your goals for your child? _____
