MEDICAL HISTORY

BIRTH HISTORY

☐ Normal pregnancy

☐Pregnancy complicated by:

☐ Pre-eclampsia ☐ Eclampsia ☐ Gestational diabetes
☐ Multiple births ☐ Premature labor ☐ Toxemia
☐ Substance exposure ☐ Rh incompatibility ☐ Anemia
☐ Bleeding
☐ Other: ____

Medications taken during pregnancy:

☐ Pre-natal Vitamins ☐ Other: ____

Length of Pregnancy: ______________________ Duration of Labor: ________________________

Birth Hospital: ____________________________ Location: ________________________________

Length of Stay: ___________________________

Medications used during Labor:
☐ None ☐ Pitocin ☐ Cervidil ☐ Morphine ☐ Stadol ☐ Fentanyl
☐ Lidocaine ☐ Epidural ☐ Nubain ☐ Other: _______________________________

Prenatal Care: ☐ Was received ☐ Was not received

Type of Delivery: ☐ Vaginal ☐ Cesarean section ☐ Emergency cesarean section

Problems during delivery:
☐ None ☐Breech presentation ☐ Transverse presentation
☐ Placenta previa ☐ Abruptio placenta ☐ Use of forceps
☐ Uterine rupture ☐ Prolapsed cord ☐ Vacuum
☐ Premature membrane rupture ☐ Umbilical cord wrapped around neck
☐ Other:____

Child's Birth weight: ______________________ Length: ____________________

Condition at birth:
☐ Jaundice ☐ Poor color ☐ Meconium aspiration ☐ Seizures
☐ Transfusions ☐ Breathing difficulty ☐ Cleft palate ☐ Cleft lip
☐ Difficulty sucking or swallowing

Any diagnosis: ____

CHILDHOOD HEALTH HISTORY

Current weight: ____________________ Current height: ______________

Current medications: ____

____

Allergies:
☐ No known allergies
☐ Yes, please list: ____

Any diagnosis given:
☐ None ☐ Yes, by whom? ______________________________

Please List: ______________________________

Does your child have any dietary restrictions?
☐ No ☐ Yes, please list ______________________________

Has your child ever been hospitalized?
☐ No ☐ Yes, please explain ______________________________

____

Is there a family history of cognitive, neurological, hearing, psychological, or hereditary problems?

☐ No ☐ Yes, please explain ______________________________

Illnesses or injuries your child has experienced:
- ☐ Chronic ear infections ☐Difficulty with sleeping ☐ Constipation/diarrhea
- ☐ Asthma ☐ Colic ☐ Reflux
- ☐ Traumatic brain injury ☐ Anoxic brain injury ☐ Tube feeding
- ☐ Cerebral vascular accident ☐ Ateriovenous malformation
- ☐ Other: ______________________________

Has your child had any seizures? ☐ No ☐ Yes. At what age? ______________

Please list any medications for seizures ______________________________

Are there any concerns regarding hearing?
☐ No ☐ Yes, please explain ______________________________

Has your child ever had his/her hearing tested?
☐ No ☐ Yes, indicate results ______________________________

Are there any concerns regarding vision?
☐ No ☐ Yes, please explain ______________________________

Has your child ever had his/her vision tested?
☐ No ☐ Yes, indicate results ______________________________

Does your child have any difficulties sleeping?
☐ No ☐ Yes, please explain ______________________________

Does your child have any bowel or bladder problems?
☐No ☐ Yes, please explain ______________________________

Has your child received any of the following services?

	When?	Where?
☐ Physical therapy	____________	____________
☐ Occupational therapy	____________	____________
☐ Speech therapy	____________	____________
☐ Developmental therapy	____________	____________
☐ Nutrition	____________	____________
☐ Audiology	____________	____________
☐ Assistive technology	____________	____________

Has your child been seen by any specialists? If so, please provide name of specialist.

☐ Allergist ________________	☐ Neurologist ________________
☐ ENT ________________	☐ Cardiologist ________________
☐ Gastroenterologist ________________	☐ Geneticist ________________
☐ Audiologist ________________	☐ Orthopedic surgeon ________________
☐ General surgeon ________________	☐ Hand surgeon ________________
☐ Oncologist ________________	☐ Thoracic surgeon ________________
☐ Psychiatrist ________________	☐ Internal medicine ________________
☐ Physiatrist ________________	☐ Endocrinologist ________________
☐ Neuro-surgeon ________________	☐ Opthamologist ________________
☐ Podiatrist ________________	☐ Other: ________________

DEVELOPMENTAL HISTORY

At what age did your child:	Age
Hold head up alone	____________
Roll over	____________
Sit alone without support	____________
Crawl/Creep alone	____________
Pull self to a standing position	____________
Walk unassisted	____________

How does your child get around at home? ____

	Never		*Sometimes*		*Always*
Does your child lose balance easily?	1	2	3	4	5
Does your child exhibit any excessive rocking, shaking head, etc…	1	2	3	4	5
Does your child bite or scratch self?	1	2	3	4	5
Does your child bit or scratch others?	1	2	3	4	5
Does your child look or pay attention to toys?	1	2	3	4	5
Does your child look or pay attention to people?	1	2	3	4	5
Does your child dislike being touched or touching things unfamiliar?	1	2	3	4	5
Does your child enjoy movement such as swinging or rough housing?	1	2	3	4	5

What are your child's favorite toys and play activities? ____

____

FEEDING, SPEECH, AND LANGUAGE HISTORY

At what age did your child: Age

- Stop using a bottle? ______________
- Stop using a pacifier? ______________
- Begin using a cup? ______________
- Begin eating baby foods? ______________
- Begin eating junior foods? ______________
- Begin eating table foods? ______________
- Name familiar objects? ______________
- Use two-word combinations? ______________
- Use complete sentences? ______________

Does your child have any feeding difficulties? ☐ No ☐ Yes, please explain: _______________

____

Please list food preferences ____

Dislikes ____

Food allergies ____

Please check any areas of difficulty your child may exhibit:

☐ Chewing ☐ Swallowing ☐ Drooling
☐ Transitioning between foods ☐ Communicating needs ☐ Understanding words

During the first year, other than crying, how would you describe your baby?

☐ A silent baby ☐ An average noisy baby ☐ A very noisy baby

How does your child communicate his/her wants/needs?

☐ Gestures ☐ Facial expressions ☐ Body language ☐ Pointing ☐ Eye gaze
☐ Sign language ☐ Vocalizations ☐ Phrases ☐ Sentences
☐ Augmentative communication system ________________________________

What were your child's first words? ________________________________ At what age? _____________

How many words does your child currently use?

☐ 0-5 ☐ 5-10 ☐ 10-20 ☐ 20-50 ☐ 50-100 ☐ > 100

Do most people understand your child's speech? ☐ Yes ☐ No

Does your child understand instructions? ☐ Yes ☐ No

How often do you repeat instructions? ____

Does your child seem to be aware of a speech difference? ☐ Yes ☐ No

What languages are spoken in the home? ______________________________________

SCHOOL HISTORY

At what age did your child start nursery or grade school? ______________________________________

What is your child's current grade level? ______________________________________

What school does your child attend? ____

Address of school ____

Phone number ______________________________ Teacher ____________________________________

What are his/her best subjects? ____

Are there subjects he or she has particular difficulty with? ____

How does your child get along with other children at school? ____

Does your child have an IEP? ☐ Yes ☐ No

What supportive services are available to your child within his or her school district? __________________

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