



Medical History

Current concerns/reason for referral: _____

Referred by _____

Past illnesses, injuries or hospitalizations _____

Current diagnosis(es) _____

Medical precautions/or limitations _____

Does your child see any specialists? (Please list) _____

Ear Infections _____ Tube placement (when) _____

Has hearing been tested? _____

Has vision been tested? _____

Medications (name, dosage, frequency and reason for medication) _____

History of seizures? Y/N

Allergies (list food, environmental, medications, etc.) _____

Food intolerances _____

Dietary Restrictions _____

Behavioral difficulties (please describe)

Does your child have a communicable disease? (hepatitis, CMV, etc) Y/N

Family History of developmental delays or learning disabilities? Y/N



Birth History

Was your child born full term? YES NO

BIRTH WEIGHT: _____ LBS _____ OZ

If your child was premature, at what week was your child born? _____ weeks gestation

REASON FOR PREMATURITY:

Did you have any complications during pregnancy? YES NO

IF YES, PLEASE DESCRIBE:

Did you have any problems during labor & delivery? YES NO

IF YES, PLEASE DESCRIBE:

Delivery was: Vaginal C-Section Emergency C-Section
 Single Birth Multiple Births

Was your child hospitalized in the NICU at any time? YES NO

Please check ALL that applies to your child during hospitalization.

Intubation Apnea episodes Required Oxygen
 Difficulty feeding Required tube feedings Surgery

Breastfed (how long) _____ or bottle fed _____ Strong suck: Y/N Frequent spit-ups: Y/N

Temperament as a baby: Irritable _____ Happy _____ Quiet _____

Developmental Milestones

Please list the age your child achieved the following skills:

Rolled over _____ Sat unsupported _____ Crawled _____
Walked _____ Babbling _____ First words _____
Combined 2 words _____ Finger fed _____ Used spoon _____
Drink from cup _____ Dressed independently _____
Toilet trained: Bladder _____ Bowel _____

FAMILY AND SCHOOL

Child lives with: Parent(s) Guardian(s) Foster parents Other:

Does your child attend daycare? Y/N Where _____

Does your child attend school? Y/N Where _____