

**1.) IDENTIFYING INFORMATION**

**DATE COMPLETED** \_\_\_\_\_

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_

Name & Relationship of person completing this form: \_\_\_\_\_

Do you have legal guardianship? Yes:  No:  If No, who does? Name/Phone \_\_\_\_\_

Primary language at home: English:  Spanish:  Other:  \_\_\_\_\_

**2.) CAREGIVER INFORMATION**

Caregiver 1	Caregiver 2 (if applicable)
Name:	Name:
Birth Date:	Birth Date:
Employer & Job:	Employer & Job:
Highest School Grade Completed:	Highest School Grade Completed:
Marital Status:	Marital Status:

**3.) SOCIAL HISTORY**

A. Please list all persons living in the child's home below:

Name	Age	Relationship to Child	Health

B. List any siblings living outside the home: \_\_\_\_\_

C. Parents:  Married  Divorced  Separated  Other

D. If separated or divorced, is there shared custody? No:  Yes:

Arrangements: \_\_\_\_\_

E. Who else cares for the child? \_\_\_\_\_

F. If applicable:

1. Was the child adopted? No:  Yes:  If Yes, at what age? \_\_\_\_\_

Circumstances of adoption: \_\_\_\_\_

2. Has the child been in foster care? No:  Yes:  If Yes, complete the following.

Circumstances: \_\_\_\_\_

Total number of foster placements: \_\_\_\_\_

G. Has your child ever experienced the following:

	Yes	No	Unsure
Serious illness, surgery, or hospitalization of a close family member?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Death of a close family member or friend?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Divorce/Separation of parents or caregivers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
House fire, flood, storm, or other disasters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or drug abuse by a family member?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing parents hitting/ hurting each other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness in a family member?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Witnessing violence (robbery, shooting, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change in primary caregiver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### 4.) PARENTAL CONCERNS

Describe what concerns you have about your child's development, learning, and/ or behavior? (Please indicate the age these concerns were first noticed.) \_\_\_\_\_

Has your child had previous evaluations for these concerns? No:  Yes:  If so, where: \_\_\_\_\_

What do you hope to accomplish during this visit? \_\_\_\_\_

##### **Describe your child's ...**

Strengths: \_\_\_\_\_

Challenges: \_\_\_\_\_

#### 5.) DEVELOPMENTAL CONCERNS

##### **A.) Speech & Language**

1. Do you have any concerns about your child's communication skills?  No  Yes, explain:

2. Does your child mostly communicate by:  Crying  Grunting  Nonspecific gesturing  Pointing index finger  
 Using single words  Using complete sentences  Using phrases  Using your hand to obtain desired object
3. Did your child begin to use words to communicate and then stopped? No:  Yes:  If Yes, at what age? \_\_\_\_\_
4. If your child uses phrases and sentences to communicate, does he/she participate in back-in-forth conversations with others?  
No:  Yes:

##### **B.) Social Development**

1. Describe your child's interactions with peers. \_\_\_\_\_
2. Does your child bring you toys or other objects? No:  Yes:
3. Does your child point to objects to show you that are interesting to him/her? No:  Yes:
4. Does your child respond to his/her name being called? No:  Yes:
5. Does your child wave goodbye or engage in any social interaction games (like Peek-a-boo, pat-a-cake, it'sy bitsy spider, ect.)?  
No:  Yes:

##### **C.) Play Skills**

Favorite toys, objects, activities: \_\_\_\_\_

Describe your child's play: \_\_\_\_\_

##### **D.) Motor Skills**

1. Do you have any current concerns about your child's motor skills?  
Gross Motor: No:  Yes:  Fine Motor: No:  Yes:
2. Does your child have problems with balance and/ or coordination? No:  Yes:

##### **E.) Sensory Skills**

1. Any concerns in the areas of: (avoids and/ or seeks out behaviors)  
 Sense of touch  Hearing  Oral  Smell  Vision  Movement  Pain Threshold  
Explain: \_\_\_\_\_

#### 6.) BEHAVIOR

- A.) How frequently does your child have temper tantrums, and how long do they last?  
\_\_\_\_\_

- B.) What typically trigger a tantrum and when do they usually occur?  
\_\_\_\_\_

- C.) What helps your child calm down?  
\_\_\_\_\_

D.) Does your child engage in any unusual repetitive behaviors? Any specific routines or interest?

E.) Other: \_\_\_\_\_

**7.) FEEDING/ NUTRITION**

Do you have concerns about your child’s eating or mealtime behavior? No:  Yes:

If you answered **Yes**, complete the following. If you answered **No**, skip to the next section (**SLEEP**)

<input type="checkbox"/> Has difficulty chewing and/or swallowing certain foods <input type="checkbox"/> Eats a limited variety of foods compared to peers <input type="checkbox"/> Gets the majority of calories from drinking <input type="checkbox"/> Is currently being treated by a gastroenterologist for feeding related concerns <input type="checkbox"/> Frequently experiences respiratory illnesses and/or has a history of pneumonia	<input type="checkbox"/> Has food allergies/ intolerance <input type="checkbox"/> Vomits multiple times per week <input type="checkbox"/> Complains frequently of stomach pains <input type="checkbox"/> Coughs and/or chokes while eating and/or drinking <input type="checkbox"/> Is dependent on tube feeds <input type="checkbox"/> Takes a long time to eat <input type="checkbox"/> Tantrums or cries during meals or refuses to eat the family meal <input type="checkbox"/> Refuses to sit at the table for meals
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**8.) SLEEP**

<b>Does your child currently have sleep problems?</b> No: <input type="checkbox"/> Yes: <input type="checkbox"/> If Yes, check all that apply:	
<input type="checkbox"/> Bedtime Refusal <input type="checkbox"/> Snoring <input type="checkbox"/> Delayed Sleep Onset	<input type="checkbox"/> Mouth Breathing <input type="checkbox"/> Restless <input type="checkbox"/> Nightmares or Terrors
<input type="checkbox"/> Teeth Grinding <input type="checkbox"/> Sleep Talking <input type="checkbox"/> Sleep Walking <input type="checkbox"/> Other <input type="checkbox"/> Will Not Sleep Alone	
Did your child have sleep problems as an infant? No: <input type="checkbox"/> Yes: <input type="checkbox"/> If Yes, explain: _____  Does your child still take day-time naps? No: <input type="checkbox"/> Yes: <input type="checkbox"/> If Yes, when and how long?	What time is your child ... In bed: _____ Asleep: _____ AM wake up: _____  Does your child have a TV in his/her bedroom? No: <input type="checkbox"/> Yes: <input type="checkbox"/>  Does your child utilize electronic media within 1 hour of bedtime? No: <input type="checkbox"/> Yes: <input type="checkbox"/>

**9.) SCHOOL HISTORY**

- A. Current school and preschool/daycare: \_\_\_\_\_ Grade: \_\_\_\_\_
- B. Are you satisfied with your child’s performance at school? No:  Yes:  If No, why? \_\_\_\_\_
- C. Does your child have an IEP (Individualized Education Plan) or a 504 plan? No:  Yes:
- D. Has your child had or is your child scheduled to have developmental and/ or psychoeducational testing? No:  Yes:
- E. Is your child receiving additional services through the school? No:  Yes:  If Yes, select from the following:
  - Self- Contained Special Education
  - Occupational Therapy (OT)
  - Resource Room
  - Physical Therapy (PT)
  - Classroom Modifications
  - Tutoring
  - Speech/Language Therapy (ST)
  - Other

**10.) THERAPY**

Has your child ever been recommended for or received therapy outside of school (e.g. Early Intervention)? No:  Yes:   
 If Yes, select from the following:

Therapy	Current	Location	Dates
Speech and Language Therapy (ST)	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Occupational Therapy (OT)	<input type="checkbox"/> No <input type="checkbox"/> Yes		

Physical Therapy (PT)	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Behavior Therapy/ Counseling	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Other	<input type="checkbox"/> No <input type="checkbox"/> Yes		

### 11.) PREGNANCY HISTORY

Did the birth mother...	No:	Yes:	What month(s) of pregnancy?	Complications and or/ medications?
Receive prenatal care?	<input type="checkbox"/>	<input type="checkbox"/>		
Have illness or medical problems?	<input type="checkbox"/>	<input type="checkbox"/>		
Have any known exposures to x-rays, toxins, or chemicals?	<input type="checkbox"/>	<input type="checkbox"/>		
Take prescription medications?	<input type="checkbox"/>	<input type="checkbox"/>		
Smoke? <i>(indicate how much)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
Drink alcoholic beverages? <i>(indicate how much)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
Use illicit drugs/ substances <i>(type and amount, if known)</i>	<input type="checkbox"/>	<input type="checkbox"/>		

### 12.) BIRTH INFORMATION

Length of pregnancy?	Birth weight?
Length of labor?	Did the baby need medical assistance in starting to breathe? No: <input type="checkbox"/> Yes: <input type="checkbox"/>
Age of mother at delivery?	Was the baby admitted to the NICU? No: <input type="checkbox"/> Yes: <input type="checkbox"/> If yes, for how long?
Labor/Delivery complications?	How long did the baby stay in the hospital after birth?
Was labor induced & why?	Did the baby have health problems in the first 12 months after birth?
Birth was ... <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Breech <input type="checkbox"/> Twins or more	

### 13.) MEDICAL HISTORY

List past medical problems, including other specialty providers caring for your child:

#### A.) Medication

List all medicines, vitamins, or supplements your child currently takes:

Name	Amount	Reason

Indicate previous medications for behavior or sleep:

Name	Dosage	Dates Taken	Response

Does your child have allergies to any medications? No:  Yes:  If Yes, to what? \_\_\_\_\_

**B.) Hospitalizations/ Surgeries**

Has your child ever been hospitalized (including psychiatric hospitalization), had surgery, and/or had a major injury? No:  Yes:

Reason	Date	Hospital

**C.) Immunizations**

Child's immunizations are ...  Up to date  Incomplete  Unknown status

**D.) Date of last Vision Test and results?**

**Date of last Hearing Test and results?**

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**E.) Previous Medical Testing?**

Test:	Result:	Date:
<input type="checkbox"/> Genetic Testing		
<input type="checkbox"/> CT Scans		
<input type="checkbox"/> MRI Scans		
<input type="checkbox"/> Sleep Study		
<input type="checkbox"/> Allergy Testing		
<input type="checkbox"/> Swallowing Studies		
<input type="checkbox"/> Other:		

**F.) Review of Systems:** Has your child ever had any of the following?

System		Age	Details	System		Age	Details
<b>Head</b>	<input type="checkbox"/> Head Injuries			<b>Lungs</b>	<input type="checkbox"/> Repeated exposure to tobacco smoke		
	<input type="checkbox"/> Hydrocephalus				<input type="checkbox"/> Asthma		
<b>Eyes</b>	<input type="checkbox"/> Vision Problems				<input type="checkbox"/> Pneumonia		
	<input type="checkbox"/> Glasses			<b>Endo</b>	<input type="checkbox"/> Height/ Growth Problem		
<b>Ears</b>	<input type="checkbox"/> Hearing Problems				<input type="checkbox"/> Diabetes		
	<input type="checkbox"/> Recurrent Ear Infections			<b>GI</b>	<input type="checkbox"/> Soiling Day/ Night		
	<input type="checkbox"/> Hearing Aids				<input type="checkbox"/> Stomachache		
<b>Nose</b>	<input type="checkbox"/> Nosebleeds			<input type="checkbox"/> Weight Problem			
	<input type="checkbox"/> Recurrent Sinus Infections			<b>MS</b>	<input type="checkbox"/> Clumsiness		
<b>Teeth</b>	<input type="checkbox"/> Teeth Grinding				<input type="checkbox"/> Weakness		
	<input type="checkbox"/> Cavities				<input type="checkbox"/> Broken Bones		
<b>Throat</b>	<input type="checkbox"/> Recurrent Strep			<b>Neuro</b>	<input type="checkbox"/> Meningitis		
<b>Allergy</b>	<input type="checkbox"/> Seasonal				<input type="checkbox"/> Headache		
	<input type="checkbox"/> Food				<input type="checkbox"/> Dizziness		

<b>Skin</b>	<input type="checkbox"/> Dermatitis/ Eczema				<input type="checkbox"/> Seizures		
	<input type="checkbox"/> Birthmarks				<input type="checkbox"/> Tics		
<b>Blood/ Lymp</b>	<input type="checkbox"/> Lead Poisoning			<b>Psych</b>	<input type="checkbox"/> Depression		
	<input type="checkbox"/> Anemia				<input type="checkbox"/> Anxiety		
	<input type="checkbox"/> Bleeding				<input type="checkbox"/> Aggression		
<b>Heart</b>	<input type="checkbox"/> Heart Defects				<input type="checkbox"/> Disruptive Behavior		
	<input type="checkbox"/> Heart Murmur				<input type="checkbox"/> Suicide/Homicidal Ideation		
	<input type="checkbox"/> Chest Pain				<input type="checkbox"/> Hallucinations		

#### 14.) DEVELOPMENTAL MILESTONES

At what age did your child meet these milestones? Indicate age in months. (If milestone has not been met, mark N/A.)

Motor	Self-help	Language
Rolled Over:	Hold bottle:	Babble:
Sit without support:	Stop using bottle:	Say Mama/Dada:
Crawl:	Fed Self:	Say another word:
Stood without support:	Use spoon:	Understand "no":
Walk Alone:	Use fork:	Point:
Run:	Drink from open cup:	Wave:
Navigate stairs:	Undress:	Follow a command:
Pedal tricycle:	Toilet trained:	Points to body parts:
Ride a bike:	Dry at night:	Use 2-word phrases:
Use a pincer grasp:	Dress self:	Use 3-word phrases:
Prefer one hand:	Tied shoelaces:	
Scribbled:		
Climbed stairs with rail:		

#### 15.) FAMILY HISTORY

No known family health problems?  Unknown, child was adopted:  Unknown for another reason:  / Explain below

Please indicate if any of the child's relatives have had any of the following (ex: parent, sibling, grandparent, aunts/uncles, cousins, etc.).

CONDITION	WHICH FAMILY MEMBER
<input type="checkbox"/> ADHD/ Attention Problems	
<input type="checkbox"/> Autism Spectrum Disorder	
<input type="checkbox"/> Behavior problems	
<input type="checkbox"/> Birth defects	
<input type="checkbox"/> Congenital Heart Disease	
<input type="checkbox"/> Cerebral Palsy	
<input type="checkbox"/> Convulsions/ Seizures	
<input type="checkbox"/> Developmental Delay	
<input type="checkbox"/> Early or Sudden Death, if so cause:	
<input type="checkbox"/> Genetic Disorder	
<input type="checkbox"/> Hearing problems/ Vision problems	
<input type="checkbox"/> Hypertrophic Cardiomyopathy	
<input type="checkbox"/> Intellectual Disability	
<input type="checkbox"/> Language/ Speech problems	

<input type="checkbox"/> Learning Problems	<input type="checkbox"/> Reading <input type="checkbox"/> Math <input type="checkbox"/> Writing <input type="checkbox"/> Other
<input type="checkbox"/> Long QT Syndrome	
<input type="checkbox"/> Tics/ Tourette Syndrome	
<input type="checkbox"/> Thyroid Disorder	
<input type="checkbox"/> Sleep Disorder	
<input type="checkbox"/> Wolff-Parkinson-White syndrome	
<input type="checkbox"/> Mental Illness:	
<input type="checkbox"/> Anxiety	
<input type="checkbox"/> Bipolar Disorder	
<input type="checkbox"/> Depression	
<input type="checkbox"/> Obsessive Compulsive Disorder (OCD)	
<input type="checkbox"/> Schizophrenia	

Please note any other relatives with conditions not listed above in the space below:

What are your primary sources of support (Example: family, friends, church, work, support group)?

**Please use the area below for any other information you feel will be helpful to use in evaluating your child.**

By providing my signature below, I affirm that I have truthfully answered the questions within this document to the best of my ability. I understand that I have an affirmative responsibility to disclose any changes to this information to the provider as they may occur.

NAME \_\_\_\_\_ DATE \_\_\_\_\_