



Child's Name: _____ Birthdate _____ Sex _____

Home Address: _____ City _____ State _____ Zip _____

Home Telephone: _____ Mobile Phone _____

Child's School _____ Grade _____

Present placement of child (Check appropriate line)

	Adult whom child Lives with	Non-Residential Adults involved involved with child
Biological Mother	_____	_____
Biological Father	_____	_____
Stepmother	_____	_____
Step father	_____	_____
Adoptive Mother	_____	_____
Adoptive Father	_____	_____
Foster Mother	_____	_____
Foster Father	_____	_____
Other (specify)	_____	_____

Source of referral _____

Brief Summary of the Main Problem:

PREGNANCY:

Complications:

Excessive Vomiting _____ Hospitalization Required _____

Threatened Miscarriage _____ Excessive staining or blood loss _____

Infections: _____ Toxemia _____ Operations _____

Smoking during Pregnancy _____ Average number of cigarettes a day _____

Alcohol consumption during Pregnancy _____ Average number of drinks a day _____

Medications during pregnancy _____



DELIVERY

Type of Labor: Spontaneous _____ Induced _____

Forceps: High _____ Mid _____ Low _____

Duration of labor _____ hours

Type of delivery Normal _____ Breech _____ Caesarean _____

Complications: Cord around neck _____ Cord presented first _____ Hemorrhage _____

Other: _____

Birth Weight _____ Delivery at _____ Weeks Gestation

POST DELIVERY PERIOD

Respiration: Immediate _____ Delayed _____ How long _____

Cry: Immediate _____ Delayed _____ How long _____

Mucus accumulation _____ Apgar score (if known) _____

Jaundice _____ Rh Factor _____ Transfusion _____ Cyanosis (turned blue) _____

Incubator care _____ Number of days _____

Suck: Strong _____ Weak _____ Vomiting _____ Diarrhea _____

Birth Defects _____ Specify _____

Total number of days baby in hospital after delivery _____

INFANCY/TODDLER PERIOD

Did not enjoy cuddling _____

Was not calmed by being held or stroked _____

Colic _____

Excessive restlessness _____

Frequent head banging _____

Constantly into everything _____

Excessive number of accidents compared to other children _____



	Age	Early	Normal	Late	Comment
Smiled					
Sat without support					
Crawled					
Walked without support					
Spoke first words					
Bowel trained					
Bladder trained					
Buttoned Clothing					
Tied Shoes					
Rode Bike without training wheels					
Said alphabet in order					

COORDINATION

	Good	Average	Below Average
Walking			
Running			
Throwing			
Catching			
Writing			
Coloring/Cutting			



MEDICAL HISTORY:

Childhood Diseases (describe any complications)

Operations: _____

Hospitalizations: _____

Head Injuries _____

Convulsions _____ Coma _____

Meningitis or encephalitis _____

Reactions to Immunizations: _____

Persistent high Fever _____ Highest temperature recorded _____

Eye Problems _____ Ear Problems _____

Poisoning _____

Present illness for which child is being treated _____

Medications taken regularly

FAMILY HISTORY - MOTHER

Age _____ Age at time of pregnancy _____

Number of previous pregnancy _____ Number of Miscarriages _____

Highest grade completed _____ Learning problems _____

Behavior problems _____

Medical Problems _____

Have any of your blood relatives had issues similar to your child? _____



FAMILY HISTORY- FATHER

Age: ____ Age of time at child's birth ____

Highest grade completed _____ Learning problems _____

Behavior problems _____

Medical problems _____

Have any of your blood relatives every had problems similar to those of your child's? _____

Child's Siblings

Name	Age	Medical, social, academic issues
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Names of other professionals consulted

Name	Facility	Phone number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Comments:

