

Prenatal Information

1. Were there any health problems during pregnancy? (such as pre-eclampsia, high Blood pressure, gestational diabetes, etc...)

2. Were there any medications beside prenatal vitamins taken during pregnancy? If so, what? _____

Birth Information

3. Were there any problems during labor or birth (complications, injury)?

No _____ Yes _____ If yes, please explain _____

4. Type of delivery (vaginal, C-section, forceps, etc.) _____

5. Was the child born full term? Yes _____ No _____ Early _____ Late _____
If premature, how many weeks early? _____ Birth weight _____

6. Were there any problems immediately after birth or in the early neonatal period? _____

Medical History

1. Does your child have any health problems or conditions? _____

2. Has your child ever been hospitalized? (If yes, please explain) _____

3. Has your child ever had surgery of any kind? _____

4. Does your child have any allergies? (Please list all known allergens, including food, medications, dander, pollen, etc.) _____

5. List any communicable diseases your child has had (i.e., chickenpox) _____

6. Has your child ever been unconscious? (If yes, please explain) _____

7. Has your child ever had a seizure? (If yes, please explain) _____

8. Has your child taken medications in the past? What type? What for? _____

9. Does your child currently take any medications on a regular or occasional basis? Please indicate name, dosage, frequency and reason for taking. _____

10. Does your child have any difficulties with:
 * sleeping habits _____
 * eating habits _____
 * elimination habits _____
11. Do you have any health concerns about your child at this time? _____

12. When was your child's last physical examination? _____
13. Who is your child's regular physician? _____
14. Does your child see a specialist of any kind? If so, please provide the names of specialist and reason. _____

Eyes

- | | <u>Yes</u> | <u>No</u> |
|---|------------|-----------|
| 1. Do your child's eyes turn in or out when tired? | _____ | _____ |
| 2. Does your child sit very close to the TV screen? | _____ | _____ |
| 3. Does your child bend over and look very closely at pictures or drawings? | _____ | _____ |
| 4. Has your child ever had an eye exam by a professional? If so, when? | _____ | _____ |

Ears, nose and throat

- | | <u>Yes</u> | <u>No</u> |
|--|------------|-----------|
| 1. Has your child had two or more throat infections in a year? | _____ | _____ |
| 2. Does your child have frequent nosebleeds? | _____ | _____ |
| 3. Does your child get swollen glands frequently? | _____ | _____ |
| 4. Does your child drool excessively? | _____ | _____ |
| 5. Does your child have frequent ear infections? | _____ | _____ |
| 6. Has your child ever had tubes in his/her ears? | _____ | _____ |
| 7. Does your child have a hearing loss with ear infections? | _____ | _____ |

Developmental History

To the best of your recollection, indicate approximate ages for the following tasks:

- | | |
|----------------------------|----------------------------------|
| * sat up unassisted _____ | * walked alone _____ |
| * crawled _____ | * ran _____ |
| * spoke single words _____ | * spoke 2-3 words together _____ |
| * bladder control _____ | * bowel control _____ |

Was your child late in feeding him/herself? _____

Motor Development

- | | <u>Yes</u> | <u>No</u> | <u>Don't Know</u> |
|---|------------|-----------|-------------------|
| 1. Does your child: | | | |
| * play successfully with puzzles, blocks and other construction toys? | _____ | _____ | _____ |
| * hold a pencil properly? | _____ | _____ | _____ |
| * write and draw rather than scribble? | _____ | _____ | _____ |
| * prefer right hand? | _____ | _____ | _____ |
| * prefer left hand? | _____ | _____ | _____ |
| * use both hands? | _____ | _____ | _____ |

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>
2. Can your child:			
* ride a tricycle?	_____	_____	_____
* throw and catch a ball?	_____	_____	_____
* alternate feet climbing stairs?	_____	_____	_____
* alternate feet descending stairs?	_____	_____	_____
3. Does your child:			
* have many accidents?	_____	_____	_____
* drop things more often than other children the same age?	_____	_____	_____
* trip easily?	_____	_____	_____
* avoid activity dirtying hands?	_____	_____	_____
* run into things?	_____	_____	_____
* have an unusual gait?	_____	_____	_____
* walk on his/her toes?	_____	_____	_____
* avoid any activity indoors, outdoors, or on the playground? (if yes, explain)	_____	_____	_____
4. Does your child:			
* usually follow directions?	_____	_____	_____
* have a very short attention span?	_____	_____	_____
5. Is your child overly sensitive to stimuli such as:			
* sound	_____	_____	_____
* environment	_____	_____	_____
* touch	_____	_____	_____
* texture	_____	_____	_____
* clothing type	_____	_____	_____
* clothing tags	_____	_____	_____

Speech

1. Does your child seem to have any difficulty understanding language?

2. Does your child seem to have any difficulty expressing him/herself?

3. Is your child's speech easily understood?
