PEDIATRIC HISTORY FORM

Child's Name: _____ **Date of Birth:** _____

Parent's Name: _____ **Phone Number:** _____

Address: _____ **Email Address:** _____

_____

Child's Diagnosis: _____

Parent's Concerns: _____

_____

Please answer all of these questions to assist us in planning treatment for your child. All information is confidential as part of your child's medical record.

Child's Primary Care Physician/Pediatrician

Name: _____ Phone: _____

Address: _____

Birth History

Was your child born on time? Yes No

If No, _____weeks early/ _____weeks late

Birth weight: _____

Number of days in hospital_____ Circle one: Regular nursery **or** Intensive care nursery

Medical History

Allergies? Yes No
If Yes, please list: _____

Is your child currently on any medications? Yes No
If Yes, please list: _____

Frequent ear infections? Yes No Tubes in ears? Yes No

Tonsils/Adenoids removed? Yes No

Significant medical history information (i.e. fractures, hospitalizations, concussions, seizures):

_____

Vision Problems: Yes No Eyeglasses? Yes No

Hearing Problems? Yes No

Are your child's immunizations up to date? Yes No
(If no, please explain)_____

Is your child being seen by any doctor/medical personnel other than a pediatrician/family practitioner? (Please circle below)

Neurosurgeon Physical Therapist Neurologist Psychologist/ Psychiatrist
Ophthalmologist Rheumatologist Ear Nose & Throat Occupational therapist
Speech therapist Other_____

Evaluations (please list the dates and results for the following if applicable):

EEG _____ CT Scan or MRI: _____ Other evaluations: _____

Developmental History (please indicate if any of the milestones below were delayed):

_____ Rolling _____ Sitting

_____ Crawling _____ Walking

_____ First words _____ Two word phrases

_____ Sentences _____ Toilet trained

_____ Buttoning & zipping clothes _____ Tying shoe laces

_____Dressing alone

Does your child have any health problems that could impact on services?
_____

_____

Is there any significant family history that could impact on your child's services?
_____

Family History

Marital Status (circle one): Single Married Separated Divorced Widowed

Siblings (please list your child's siblings):
Name Age Medications School/grade
1. _____ 2._____

3. _____4._____

Please list any community activities that your child is involved in:

Clubs:
_____

Sports:
_____

Other:
_____

Educational History

1) What school does your child attend? _____

Regular Education Special Education

2) What grade is your child in?
_____

3) Grade in which school difficulty first arose:
_____

3) Does your child receive any services in school? *(If yes, please list below).* Yes No

Occupational Therapy Physical Therapy Speech Therapy Other: _____

Activities of Daily Living

Does your child have any difficulty performing age appropriate activities listed below? *(Check all that apply)*

Bathing	Dressing	Brushing Teeth
Climbing Stairs	Running	Using Utensils
Balancing	Sitting	Walking
Feeding	Socialization	Paying Attending
Writing	Buttoning	Zipping
Lacing	Communicating	Catching/Throwing

X_____ _____
Parent Signature Date

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