Please circle appropriate answer. If answer is "yes," please allow PHYSICIAN to complete this information.

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## Initial Patient History Form

Patient Name: _____
Date of Birth: _____

### BIRTH HISTORY:

* There were problems: No/Yes _____
* Mother had prenatal care: No/Yes _____
* Drug/tobacco/alcohol use during pregnancy: No/Yes _____
* Twin pregnancy: No/Yes _____
* 2nd/3rd trimester bleeding: No/Yes _____
* Preterm labor/diabetes: No/Yes _____
* Pre-eclampsia/high blood pressure: No/Yes _____
* Maternal injury: No/Yes _____
* Maternal medication: No/Yes _____
* Decreased fetal movement: No/Yes _____
* Maternal X-rays: No/Yes _____
* Maternal illness with fever/rash: No/Yes _____
* Other maternal illness: No/Yes _____

* Delivery was: Normal Breech Vacuum Forceps C-section
* Amniotic Fluid was: Clear Foul smelling Too much Too little
* Baby was born: Full-term Premature: _____
* Baby's birth weight was: _____lb _____ oz
* Baby was cared for in: Room w/mother Regular nursery Step-down unit Intensive care
* Complications at birth: No/Yes: _____

*Baby went home at: _____ days of age Baby fed well, gained weight, and thrived: Yes/No _____

### PAST MEDICAL HISTORY:

* There were problems: No/Yes _____
* Head injury with loss of consciousness: No/Yes _____
* Brain/spinal infection: No/Yes _____
* Other severe illness: No/Yes _____
* Febrile seizures or other seizures: No/Yes _____
* Hospitalization: No/Yes _____
* Surgery: No/Yes _____
* Vision/hearing problems: No/Yes _____
* Takes medication on daily basis: No/Yes _____
* Allergy to medication: No/Yes _____
* Immunizations up to date: No/Yes _____

### EDUCATION:

* Child is in grade: _____ at _____School.
* Child has problems with inattention or hyperactivity: No/Yes _____
* Child has problems with learning: No/Yes _____
* Child is in Special Education: No/Yes _____
* Child received services: No/Yes _____
* School/other testing has been done: No/Yes _____

**PLEASE FLIP PAGE OVER**

DEVELOPMENTAL HISTORY: Development was: Normal Delayed

*** Fill out this section ONLY if development is DELAYED**

| Gross Motor | Age (mos) | Fine motor | Age (mos) | Communication | Age (mos) | Adaptive | Age (mos) |
|---|---|---|---|---|---|---|---|
| Lifts head | | Focuses/follows | | Smiles | | Regards hand | |
| Rolls over | | Hands to midline | | Coos | | Waves/pat-a-cake | |
| Sits alone | | Reaches | | Laughs/turns to voice | | Finger foods | |
| Crawls | | Transfers | | Babbles | | Drinks from a cup | |
| Stands | | Holds bottle | | Mama/Dada | | Feeds self w/ spoon | |
| Cruises | | Pincer grasp | | **First words** | | Uses fork | |
| **Walks** | | Intentional release | | Points/gestures | | Washes/dries hands | |
| Runs | | **Scribbles** | | Follows commands | | **Toilet trained** | |
| Jumps | | Imitates strokes | | Body parts/**2-word phrases**/50 words | | Brushes teeth | |
| **Rides tricycle** Up/downstairs | | Imitates circles | | Use 3+ sentences/says full name/ 250 words | | Undresses/**dresses self** | |
| Hops, balances on 1 foot | | **Draws a square** 5-block bridge | | Follows 3-step command Colors/tells stories | | Buttons & unbuttons Group play | |
| Skips | | Draws a triangle 6-block staircase | | Knows home address Counts | | Ties shoes Domestic play | |
| Rides bike | | Draws diamond 10-block staircase | | Define words/reads | | **Prepares cereal** | |

FAMILY HISTORY: Please circle the appropriate information about **other** family members:

* Migraine headaches: No/Yes _____
* Seizures or convulsions: No/Yes _____
* Developmental delay: No/Yes _____
* Mental retardation: No/Yes _____
* Cerebral palsy: No/Yes _____
* Learning disability: No/Yes _____
* Attention deficit/hyperactivity: No/Yes _____
* Muscle or nerve disease: No/Yes _____
* Brain tumor/abnormal blood vessel in brain: No/Yes _____
* Stroke at young age: No/Yes _____
* SIDS/other death at young age: No/Yes _____
* Birth defect: No/Yes _____
* Chromosomal abnormality: No/Yes _____
* Genetic disorder: No/Yes _____
* Drug/alcohol abuse: No/Yes _____
* Psychiatric disorder: No/Yes _____
* 3 or more miscarriages by mother: No/Yes _____
* Parents blood related to each other: No/Yes _____
* Progressive vision/hearing loss: No/Yes _____

SOCIAL HISTORY: Please circle and fill-in appropriate information.

* Child lives with: Both parents Mother Father Other: _____
* Parents are: Married Divorced Separated Unmarried Single
* Foster-care at present: No/Yes _____ * Foster-Care in past: No/Yes _____
* Mother's age: _____ Occupation: _____ Level of education: _____
* Father's age: _____ Occupation: _____ Level of education: _____
* Child's brothers & sisters are ALL normal and healthy: Yes/No _____
* List ages of the child's: Brothers: _____
  Sisters: _____