Pediatric History Form

CLIENT INFORMATION

Name of Child: _____

Date of Birth: _____ Chronological Age: _____

Gestational Age: _____ Current Weight: _____

Mother's name and address:
(or primary caregiver)

_____

_____

_____

Phone: _____

Email: _____

Physician: _____

Father's name and address:
(or secondary caregiver)

_____

_____

_____

Phone: _____

Email: _____

Referred by: _____

Reason for Referral: _____

CURRENT STATUS

What is the child's medical diagnosis? _____

What are the present concerns? _____

Has the problem changed? (or gotten better or worse?) _____

Are there any times when the problem is better or worse? _____

_____

CURRENT STATUS

With whom is the child living? _____

Names and ages of siblings: _____

Who are the primary caregivers? _____

Who usually feeds the child? _____

Does the child attend daycare or school? _____

Does the child receive any special education services? If yes, describe: _____

_____

MEDICAL HISTORY

List maternal illnesses or infections during pregnancy: _____

_____

List any problems during pregnancy: _____

_____

List any medications taken during pregnancy: _____

_____

Lists tests or x-rays during pregnancy: _____

_____

Was alcohol or any drug used before/during pregnancy by either parent? _____

Length of pregnancy in weeks: _____ Duration of labor: _____

Type of delivery: ____ head first ____ feet first ____ Cesarean ____ Breech

Birth weight: _____

List any problems during labor and delivery: _____

_____

Was anesthesia used during birth? (if yes, for what reason?) _____

_____

Apgar scores: 1 minute _____ 5 minutes _____

Was ventilation support needed at birth? Yes ____ No ____

Were there any other complications after birth? _____

List any medications that the child is currently taking: _____

_____

List and describe any surgeries the child has had: _____

_____

Has any genetic or neurologic testing been conducted? (if yes, explain.) _____

_____

Has the child experienced any of the following illnesses? ____ ear infections ____ high fevers

____ allergies or asthma ____ seizures ____ frequent upper respiratory infections

____ Pneumonia

Other illnesses: _____

Please list any food allergies or sensitivities: _____

Describe the child's sleep patterns: _____

_____

Is the child irritable at times? (if yes, when?) _____

Does the child experience frequent constipation or diarrhea? _____

Is the child toilet trained? Bladder: ____ yes ____no Bowel: ____ yes ____no

MOTOR DEVELOPMENT

At what age did the child: sit alone _____ crawl _____ stand _____

walk independently _____ jump _____

Does the child have a hand preference? (if so, which hand?) _____

Describe gross and fine motor problems _____

_____

COMMUNICATION HISTORY

Would you describe the child as quiet, noisy, or average? _____

At what age did he or she start babbling or imitating sounds? _____

At what age did he/she use 1-4 words? What were they? _____

_____

At what age did the child use two words together? Please give examples: _____

_____

How many words does he/she use now approximately? _____

How well is the child's speech understood? _____

How does the child communicate his/her needs? _____

What types of questions does the child understand well? _____

What types of directions are difficult for the child? _____

Describe the child's voice quality: _____

____ breathy _____ shrill _____ nasal sounding _____ gurgly ____ weak

Voice pitch: _____ normal _____ too high _____ too low

Voice volume: _____ normal _____ weak _____ loud

Please describe any difficulties or strengths in reading, writing or spelling?

_____

_____

_____

_____

DESCRIBE THE CHILD'S PERSONALITY

What are his/her likes and dislikes? _____

_____

What toys and activities does the child enjoy? _____

_____

Any fears? _____

What kinds of situations frustrate the child? _____

What behaviors have caused the child to be disciplined? _____

What types of discipline have been used? _____

What kinds of things can the child do himself/herself? _____

_____ dressing _____ bathing _____ toileting _____ shoes on _____ shoes tied _____ use spoon

_____ fork _____ knife _____ open cup _____ use straw

Other? _____

What is the child's usual bedtime and rising time? _____

Does the child nap? _____ How long? _____

Are there any sleep problems? ____ snoring ____ mouth breathing ____ lengthy night waking

Other: _____