



Body

Growing Together in Mind and



PEDIATRIC HISTORY FORM

CLIENT INFORMATION

Child's Name: _____ Preferred Name: _____

Date of Birth: _____ Male ☐ Female ☐ Preferred Pronouns: _____

Chronological Age: _____ Gestational Age: _____

Birth Weight: _____ Current Weight: _____

CURRENT STATUS

What is your child's medical diagnosis: _____

What are the present concerns? _____

Have the concerns changed (gotten better or worse)? _____

Are there any times when the concerns are better or worse? _____

Other family members in the home: _____

Names and ages of siblings: _____

Who are the primary caregivers? _____

Who usually feeds the child? _____

Does your child attend daycare or school? _____

Does your child receive any special education services? If yes, describe. _____



The Therapy Tree, LLC | 89 Cedar Ave. P.O. Box 764 Lake Villa, IL 60046

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MEDICAL HISTORY

List any maternal illnesses or infections during pregnancy. _____

List any problems during pregnancy. _____

List any medications taken during pregnancy. _____

List tests or x-rays during pregnancy. _____

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

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

Type of delivery: ____ head first ____ feet first ____ cesarean ____ breech

List any problems during delivery. _____

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

Apgar scores: 1 minute ____ 5 minutes ____

Was ventilation support needed at birth? _____

Were there any other complications after birth? _____

List any medication that the child is currently taking. _____

List and describe any surgeries your child has had. _____

Has any genetic or neurological testing been conducted? (If yes, explain) _____



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Has your child experienced any of the following illnesses? ____ ear infections ____ high fevers
____ allergies or asthma ____ seizures ____ frequent upper respiratory infections ____ pneumonia

Other illness: _____

Please list any food allergies or sensitivities. _____

Describe your child's sleep patterns. _____

Is your child irritable at times? If so, when? _____

Does your child experience frequent constipation or diarrhea? _____

Is your child toilet trained? Bladder ____yes ____no, Bowel ____yes ____no

MOTOR DEVELOPMENT

At what age did your child: sit alone ____, crawl ____, stand ____, walk independently ____,
Jump ____

Does your child have a hand preference? If so, which hand? _____

Describe any gross and/or fine motor problems. _____

COMMUNICATION HISTORY

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

At what age did your child start babbling or imitating sounds? _____

At what age did your child use 1-4 words? What were they? _____

At what age did your child use two words together? Please provide examples. _____

How many words does your child approximately use now? _____

How well is your child's speech understood? _____



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What type of questions does your child understand well? _____

What type of directions are difficult for your child? _____

Describe your 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. _____

CHILD'S PERSONALITY

What are your child's likes and dislikes? _____

What toys and activities does your child enjoy? _____

Does your child have any fears? _____

What kind of situations frustrate your child? _____

What behaviors have caused your child to be disciplined? _____

What type of discipline is used? _____

What kinds of things can your child do themselves? _____

____dress ____bathe ____toilet ____put shoes on ____tie shoes ____use spoon ____use fork

____use knife ____open cup ____use straw

Other? _____

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

Does your child nap? If so, for how long? _____



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Are there any sleeping problems? ____snoring ____mouth breathing ____lengthy nigh walking

Other? _____

Form completed by:

Printed Name of Client or Parent/Guardian

Client or Parent/Guardian Signature

Date signed

