Medical History

Date:____

Child's Name: ____

Date of Birth: ____

Please list any medical or school evaluations (copies of the evaluation report are greatly appreciated) your child has completed and any diagnoses that may have been given:

____
____
____
____

Has your child had a current *hearing* evaluation, yes, when and describe results:

____

Has your child had a current *vision* evaluation, if yes, when and describe results:

____

Please list any current medications:

____
____
____

Has your child ever received or is currently participating in (please check all that apply and list organization/services provided):

- ☐ Early Intervention ____
- ☐ Occupational Therapy ____
- ☐ Physical Therapy ____
- ☐ Speech services ____
- ☐ Counseling ____
- ☐ ABA ____

Does your child have any allergies (food, medication, etc.)? YES NO
If, yes, please list: ____
____
____

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Is your child on a special diet? YES NO
If, yes, please describe:____

Is your child enrolled in an educational program? YES NO
If, yes, please note that program and address:
____
____

Do you have any academic or social concerns at this time? YES NO
If, yes, please describe:____
____
____
____

Birth/Early Childhood History

Length of Pregnancy: ____________________ weeks

Delivery and complications, if any:____
____
____

Child's birth weight:______________________________

Did your child experience any post-natal difficulties?
____
____

Did you child spend any time in the Neonatal Intensive Care Unit? YES NO
If, yes, please describe:____
____
____

Does your child have a history of (please check all that apply):

- ☐ Gastroesophageal Reflux (GERD)
- ☐ Intrauterine Growth Restriction (IUGR)
- ☐ Torticollis
- ☐ Premature birth
- ☐ Vision impairment
- ☐ Hearing impairment
- ☐ Respiratory impairment

When did your child start to (approximations are okay):

Roll: ____________________________________
Sit independently:_________________________
Crawl:___________________________________
Walk:____________________________________
Jump:____________________________________
Climb stairs:______________________________

Is your child able to:

	YES	NO	Sometimes
Take off clothing items			
- Socks/shoes			
- Pants			
- Shirt			
- Coat			
Put on clothing items			
- Socks/shoes			
- Pants			
- Shirt			
- Coat			
Participate in teeth brushing			
Participate in bathing			
Drink from an open cup			
Use a straw			

Please describe your child's current toileting status (independent, diapers, practicing, refuses, withholds, etc.):
____
____
____

Please describe your child's current sleep routine and status (falls asleep independently, but trouble staying asleep; restless; sleeps in their own room; shares a room with sibling, etc.):
____
____
____

What are your child's preferred toys/activities:
____
____
____

Please list and/or attach any other important information you would like to share with us:

____

____

____

____