DATE:_____

PATIENT NAME: _____**D.O.B.**_____

DOES THIS CHILD HAVE ALLERGIES? YES/NO TYPE OF ALLERGY: _____

PLEASE INDICATE DETAILED REASON(S) FOR THIS VISIT:

1. _____
2. _____
3. _____

DEVELOPMENTAL HISTORY:

APPROXIMATELY AT WHAT AGE DID THIS CHILD:

SMILE	_____	**RIDE A TRICYCLE**	_____
HAVE HEAD CONTROL	_____	**RIDE A BICYCLE**	_____
SIT ALONE	_____	**STOP DROOLING**	_____
CRAWL	_____	**SAY HIS/HER FIRST WORD**	_____
STAND ALONE	_____	**TALK IN SENTENCES**	_____
WALK UNASSISTED	_____	**TIE SHOELACES**	_____
BUTTON OWN CLOTHES	_____	**TOILET TRAIN**	_____

MEDICAL HISTORY AND TREATMENTS:

HOSPITALIZATIONS: YES/NO NAME OF HOSPITAL: _____
DATE OF HOSPITALIZATION: _____

DOES THIS CHILD HAVE ANY IMPAIRMENT(SPEECH, VISUAL, HEARING, PHYSICAL, LEARNING, ETC.)?

_____

HAS THIS CHILD HAD SPEECH THERAPY? YES/NO WHEN: _____ **WHERE:**_____

HAS THIS CHILD HAD PSYCHOTHERAPY? YES/NO WHEN:_____**WHERE:**_____

IS THIS CHILD CURRENTLY ON MEDICATION? YES/NO

CURRENT MEDICATION: _____ **DATE STARTED:**_____
_____ _____

PAST MEDICATIONS: _____ **DATE STARTED:**_____
DISCONTINUED:_____

PAST MEDICATIONS: _____ **DATE STARTED:**_____
DISCONTINUED:_____

RECENT TESTING: _____

DOES THE CHILD HAVE ANY RELIGIOUS/CULTURAL RESTRICTIONS?

_____

DATE:_____

PATIENT NAME: _____**D.O.B.**_____

DOES THIS CHILD:	**SMOKE**	**YES/NO**
	DRINK	**YES/NO**
	TAKE DRUGS	**YES/NO**

NAME OF CURRENT SCHOOL:_____

CURRENT GRADE:_____

HAS PATIENT BEEN HELD BACK/REGRESSED IN ANY GRADE? YES/NO
PLEASE EXPLAIN:_____

ABOUT THE MOTHER:

NAME _____ **AGE** _____

AGE OF MOTHER WHEN PREGNANT WITH THIS CHILD: _____

MONTHS OF PREGNANCY: _____

CHILD'S BIRTH WEIGHT: _____ **LBS** _____ **OZ** **HEIGHT:** _____

LIST ANY MEDICATIONS TAKEN DURING PREGNANCY _____
_____

LEARNING DIFFICULTIES:	**YES/NO**
SPEECH DIFFICULTIES:	**YES/NO**
MEDICAL PROBLEMS:	**YES/NO**
STUTTERING:	**YES/NO**

ABOUT THE FATHER:

NAME _____ **AGE** _____

LEARNING DIFFICULTIES:	**YES/NO**
SPEECH DIFFICULTIES:	**YES/NO**
MEDICAL PROBLEMS:	**YES/NO**
STUTTERING:	**YES/NO**

Family History:

Relative (Mother, father, sister, etc.)	**AGE**	**MEDICAL PROBLEMS:**
_____	_____	_____
_____	_____	_____
_____	_____	_____