



PEDIATRIC CONFIDENTIAL HISTORY

Today's Date: _____ Child's Name: _____

Childcare/School: _____

Grade: _____ Person(s) completing form: _____

PAST HISTORY

Birth: Baby's weight at birth: _____

yes no premature? How many weeks early? _____

yes no forceps/vacuum delivery? no yes cesarean delivery?

yes no labor medications? _____

yes no long labor? How long? _____

yes no oxygen required? How long? _____

yes no APGAR score concern? _____

yes no intensive care? How long? _____

yes no Pregnancy history (stress, nutrition, complications, infections, etc.)? Describe:

yes no Other significant problems during/after birth (i.e., stuck in pelvis, birth injuries, etc.)?

Describe: _____

How well did your child nurse? _____

Describe your child's infancy (mood/affect, sleeping, etc.): _____

Has your child ever: yes no had any broken bones? yes no been in an accident?

yes no had any operations? Other medical health issues? _____

Developmental milestones (please fill in ages):

First words _____ Crawled _____ Walked independently _____

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CURRENT HISTORY

Does your child receive special education services?

yes no (If yes, please attach IEP/Individualized Education Plan)

Please describe your child's living situation. Please include who lives in the home with your child and ages of siblings: _____

If your child has a diagnosis by a physician, please share: _____

When diagnosed? _____

Who made the diagnosis? _____

Is your child currently doing any alternative health programs?

(ex. special diets, supplements or alternative therapies) yes no _____

List any medications your child is taking and the purpose for taking each: _____

Does your child have any precautions we should know about such as allergies, seizures, or special diets? _____

Please circle any physical symptoms that apply:

Tubes in ears Ear infections Indigestion Stomachaches Eating difficulty

Lack of dizziness Reflux/GI issues Constipation Headaches Allergies Asthma

Seizures Respiratory difficulty Heart ailments Inner tension Sinus trouble

Describe: _____

Please check any emotional/behavioral symptoms that apply:

Often, my child can be described as: (please circle all that apply)

cooperative willing to try new activities stubborn withdrawn separation difficulties

avoids eye contact seems more tired than expected seems more active than peers

restless impulsive destructive aggressive easily frustrated self-abusive

easily distracted short attention span difficulty following directions immature behavior

Present symptoms and child's major challenges: _____

What seems to make things worse? _____

What do you think may be going on with your child that is causing the problems? _____

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What do you typically need to do when your child is having problems? _____

Have they prevented your child from going to school? yes no Hospitalized child? yes no

What behaviors do you observe in your child when dealing with frustration/conflict? _____

Difficulties with School? yes no Describe _____

Difficulty with: focus yes no following directions yes no sitting still yes no

Phy ed yes no handwriting yes no keeping hands to self yes no

Switches hands during coloring/writing? yes no Avoids coloring/writing? yes no

Difficulties with sleep? yes no Describe _____

_____ Uses: weighted blanket yes no

Background noise yes no Melatonin yes no Medication yes no

Sleeps in own bed yes no Sleeps thru night yes no If no, how many times awake? _____

Bedtime: _____ Time child falls asleep: _____ Time child wakes: _____

Describe challenges: _____

Difficulty with Mealtime: yes no Describe _____

Difficulty with: using fork/spoon yes no sitting through meal yes no

spilling frequently yes no going to restaurants: yes no

Difficulty with Dressing: yes no Describe _____

Difficulty with: zippers yes no tying shoes yes no staying on task yes no

My child: refuses to wear coat yes no often puts clothes/shoes on backward yes no

puts on coat, excluding zipper yes no puts coat on using a learned strategy yes no

Difficulty with Daily Routine: yes no Describe _____

Difficulty with making transitions yes no My child seems more active than others yes no

More often than peers, my child: trips yes no runs into things yes no falls down yes no

Safety concerns yes no Describe _____

Difficulty going to stores: yes no Describe _____

My child often: wanders off in public yes no does not come back when called: yes no

is aware of dangers in public (strangers, crossing streets/parking lots, etc.): yes no

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Challenges with Play: yes no Describe _____

Difficulty with: sports yes no Describe _____

Able to: ride bicycle without training wheels yes no pump swing without help yes no

When playing: avoids strenuous activity yes no moves quickly between activities yes no

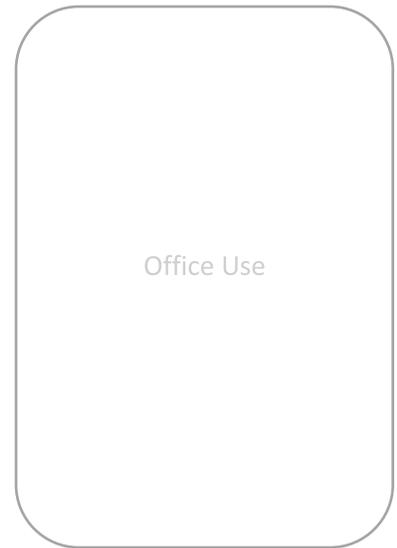
tends to W-sit yes no accident prone yes no Seems to have weak muscles yes no

Toileting skills:

Daytime accidents? yes no How often? _____

Nighttime accidents? yes no How often? _____

Percentage of time he/she initiates going without prompts _____



RELEASE OF INFORMATION

Professional Type	Name and Phone Number	Permission to Release
Primary Physician & Clinic name		<input type="checkbox"/> yes <input type="checkbox"/> no
Specialty Physician & Clinic name		<input type="checkbox"/> yes <input type="checkbox"/> no
Mental Health & Clinic name		<input type="checkbox"/> yes <input type="checkbox"/> no
OT/PT/SLP therapist & Clinic name		<input type="checkbox"/> yes <input type="checkbox"/> no
School or Daycare (educational/therapy staff, IEP team)		<input type="checkbox"/> yes <input type="checkbox"/> no
Autism services provider		<input type="checkbox"/> yes <input type="checkbox"/> no
Other		<input type="checkbox"/> yes <input type="checkbox"/> no

Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship to client: _____