

patient name _____ date of birth _____ social security number _____ sex _____

mother's name _____ father's name _____

legal guardian's name _____ relationship _____

parent's street address _____ state _____ zip _____

guardian's phone _____ emergency phone _____

Please list all those living in the child's home (and all who we can see with him/her)

name	relationship	date of birth	health problems	may the child be seen with this person	
_____	_____	_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no

Birth History

birth weight (lbs/oz) _____ hospital _____ list current medications _____

Was the baby born at term? yes no *If no, how early / late?* _____

Did the mother have any illness or problem during her pregnancy? yes no *If yes, explain:* _____

During pregnancy, did mother: smoke drink alcohol drugs or medications *What/When:* _____

The delivery was: vaginal cesarean *If cesarean, why?* _____

Did the baby have any problems right after birth? yes no *If yes, explain:* _____

Did the baby go home with the mother from the hospital? yes no *If no, explain:* _____

Initial feeding: breast bottle

General

yes no explain

Do you consider your child to be in good health? yes no _____

Does your child have any serious illness or medical condition? yes no _____

Has your child had any serious injuries or accidents? yes no _____

Has your child had any surgery? yes no _____

Has your child ever been hospitalized? yes no _____

Is your child allergic to any medicines or drugs? yes no _____

Development

yes no explain

Are you concerned about your child's physical development? yes no _____

Are you concerned about your child's mental or emotional development? yes no _____

Are you concerned about your child's attention span? yes no _____

If your child is in school:

How is his/her behavior in school? yes no _____

Has he/she failed or repeated a grade in school? yes no _____

How is he/she doing in academeic subjects? yes no _____

Is he/she in special or resource classes? yes no _____