

Please answer the following questions carefully. Your answers will help us in trying to identify problems that may affect you or your child's health. Completing this form before your visit with us will help to speed the evaluation process. All information will be kept CONFIDENTIAL, Please mail this form back to us in the enclosed envelope if there is time before your appointment; otherwise please bring it with you on the day of your appointment. Thank you!

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**A. DEVELOPMENTAL HISTORY**

When did your child first show these skills (what age)?

- \_\_\_\_\_ Smile
- \_\_\_\_\_ Reach for objects
- \_\_\_\_\_ Transfer objects from hand to hand
- \_\_\_\_\_ Roll over
- \_\_\_\_\_ Sit with help
- \_\_\_\_\_ Sit alone
- \_\_\_\_\_ First words
- \_\_\_\_\_ Crawl
- \_\_\_\_\_ Walk with help
- \_\_\_\_\_ Walk alone
- \_\_\_\_\_ Put words together in a sentence
- \_\_\_\_\_ Toilet trained

Is your child in a playgroup or in school? YES      NO  
 Where and what grade? \_\_\_\_\_

Is your child receiving any special help at school (such as speech or resource)? YES    NO  
 What? \_\_\_\_\_

Has your child ever been evaluated at a developmental center (Watkins Center, Shelby or Concord DEC, Child & Family Development, etc.)? YES      NO  
 Where? \_\_\_\_\_

- What were the results of the testing'?
- \_\_\_\_\_ Child's age when testing done
  - \_\_\_\_\_ Overall ace level
  - \_\_\_\_\_ Gross motor level
  - \_\_\_\_\_ Fine motor ace level
  - \_\_\_\_\_ Overall language level
  - \_\_\_\_\_ Expressive language level
  - \_\_\_\_\_ Receptive language level

- Is your child receiving any therapies?
- \_\_\_\_\_ Speech therapy
  - \_\_\_\_\_ Physical therapy
  - \_\_\_\_\_ Occupational therapy
  - \_\_\_\_\_ Other therapy

**B. MEDICAL HISTORY**

Who is your child's pediatrician/family doctor? \_\_\_\_\_

Are your child's immunizations up to date?    YES    NO

Is your child on any medications? YES    NO

Medications? \_\_\_\_\_

Does your child have any allergies? YES    NO

Allergies? \_\_\_\_\_

Since we saw you last, has your child had any major illnesses or been hospitalized?

YES    NO

When/where/why? \_\_\_\_\_

Since we saw you last, has your child seen any special doctors?

- \_\_\_\_\_ Audiology
- \_\_\_\_\_ Cardiology
- \_\_\_\_\_ Endocrinology
- \_\_\_\_\_ Ear, nose, & throat
- \_\_\_\_\_ Genetics
- \_\_\_\_\_ GI
- \_\_\_\_\_ Nephrology
- \_\_\_\_\_ Neurology
- \_\_\_\_\_ Ophthalmologist
- \_\_\_\_\_ Orthopedist
- \_\_\_\_\_ Plastic surgery
- \_\_\_\_\_ Surgeon
- \_\_\_\_\_ Urology
- \_\_\_\_\_ Other

Who? \_\_\_\_\_

Since we saw you last, has your child had any special tests done?

- \_\_\_\_\_ Blood tests
- \_\_\_\_\_ CT
- \_\_\_\_\_ Scan
- \_\_\_\_\_ EEG
- \_\_\_\_\_ Echocardiogram
- \_\_\_\_\_ MRI scan
- \_\_\_\_\_ Ultrasound
- \_\_\_\_\_ X-rays
- \_\_\_\_\_ Other

What were the results? \_\_\_\_\_

**C. FAMILY HISTORY**

Since we saw you last, have there been any changes in your family history (new babies, a family member diagnosed with a birth defect and/or mental retardation, deaths, etc.)? YES NO

What are your main concerns regarding your child?