CHILD HISTORY FORM

Date_____

Child's Name_____ Date of Birth_____

Address_____ Phone_____

City _____State _____ Zip_____ Sex_____ Race_____

Age_____ Grade_____ School_____

Father's Name_____ Date of Birth_____

Address_____ Home Phone_____

_____Zip_____ Cell Phone_____

Email address_____

Employer_____ Work Phone_____

Employer Address_____ Race_____

_____

Mother's Name_____ Date of Birth_____

Address_____ Home Phone_____

_____Zip_____ Cell Phone_____

Email address_____

Employer_____ Work Phone_____

Employer Address_____ Race_____

_____

How were you referred to this office? _____

Birth History: (circle all that apply)

Adopted Full-Term Pre-Term at _____weeks Vaginal

C-Section Breech Vacuum Extraction

Fetal Distress Required Oxygen Admitted NICU for how long? _____

Explain/Other: _____

_____

Brothers/Sisters Age/Grade

_____ _____

_____ _____

_____ _____

Health History: Has your child had….

Frequent colds, fevers? _____ Asthma or Allergies? _____

Allergies to? _____

Ear Infections? _____ How Many? _____ Age first time? _____

Hearing Tested? _____ When/Where? _____ Results? _____

Diagnosed ADHD/ADD? _____ Diagnosed LD? _____

Psychological Evaluation? _____ When? _____ Where? _____

Other Health problems, Surgeries, or Hospitalizations? _____

_____

Current Medications? _____

Developmental History: List age when child first…

Sat alone_____ Crawled_____ Walked_____

Ate stage I foods_____ stage III_____ table foods_____

First Words_____ weaned to cup_____ gave up bottle_____

Gave up pacifier_____ "spouted" cups_____

List other developmental delays: _____

_____

Does your child receive any special services in school? List._____

_____

What concerns have brought you to this evaluation/treatment? _____

_____