

Child's Name:**Date of Birth:****Name of Person Completing Form:****Relationship to Child:****Date Form Completed:****Teacher Name(s):****Counselor Name(s):****Chief Concerns:****Prescription medications:**

<i>Name</i>	<i>Dose</i>	<i>Time of Day Taken</i>

Over-the-counter medications (like claritin, zyrtec, etc):

<i>Name</i>	<i>Dose</i>	<i>Time of Day Taken</i>

Supplements (like vitamins, omega-3, melatonin, etc):

<i>Name</i>	<i>Dose</i>	<i>Time of Day Taken</i>

Past Medical History Prenatal/Perinatal Check or answer in space provided.		
Pregnancy and Birth History	No	Yes
Prenatal vitamins during pregnancy?		
Other medication during pregnancy?		
If yes, what medication (s)?		
Any substance use (alcohol, tobacco, illegal drugs) during pregnancy?		
If yes, which substance?		
If substance use, during which part of pregnancy (trimester or month)?		
Fever during pregnancy?		
Influenza during pregnancy?		
Infection during pregnancy?		
If yes, please provide details:		
Complications during pregnancy?		
If yes, please provide details:		
Medical concerns about this child during pregnancy?		
If yes, please provide details:		
Birth weight:		
Apgar score at 1-minute and 5-minute:		
Delivered at term (38 weeks or more)?		
If preterm, how many weeks of gestation?		
Neonatal problems?		
If yes, please provide details:		
Presumed infection at birth?		
Confirmed infection at birth?		
If yes, what type of infection was found?		
Congenital infection?		
If yes, what type of infection was found?		
Breathing problems at birth?		
If yes, circle which type of support was required: oxygen, CPAP, ventilator		
If ventilator, circle which type: JET, oscillator, regular/conventional, other		
If ventilator of any type, for how long?		
Hemorrhage in/near/around brain?		
If yes, specify location and grade:		
Retinopathy of prematurity?		

Past Medical History By System	No	Yes		No	Yes
General Health Section:			Muscles/Limbs:		
Obesity?			Right-handed?		
Underweight?			Left-handed?		
Picky eater?			Any impaired or missing limb?		
Head:			If yes, which?		
Head trauma?			Any impaired balance?		
Concussion?			Any coordination difficulty or clumsiness?		
Eye:			If yes, diagnosis:		
Eye disease?			Any limp or abnormal position during walking?		
If yes, what type?			Any limp or abnormal position during running?		
Vision problem?			Neurology:		
If yes, what type?			Tic disorder?		
Eye doctor's name?			Restless leg syndrome?		
Ear/Nose/Throat:			Sleep disorder?		
Seasonal allergies?			If yes, what type?		
To what?			Febrile seizure?		
Year-round allergies?			Seizure disorder?		
To what?			If yes, what type?		
Recurrent ear infections?			Autism?		
Recurrent sinus infections?			If yes, specify type:		
Hearing problems?			Asperger's syndrome?		
If yes, is it correctable?			Sensory Processing Disorder?		
ENT doctor's name?			Sensory Integration Disorder?		
Enlarged tonsils?			Cerebral palsy?		
Enlarged adenoids?			If yes, specify type:		
Sleep apnea?			Mental retardation?		
Snoring?			Neuromuscular disorder?		
Swallowing difficulty?			If yes, specify type:		
Heart:			Neurologist's name?		
High blood pressure (hypertension)?			Genetics/Metabolism:		
Heart murmur (not innocent/benign/functional)?			Genetic syndrome?		
Heart problems?			If yes, specify type:		
Rheumatic fever?			Metabolic disorder?		
If yes to any, cardiologist's name?			If yes, specify type:		
Chest pain?			Psychiatric:		
Palpitations?			Depression?		
Lungs:			Anxiety?		
Asthma?			Mood disorder?		
Other lung disease?			Bipolar disorder?		
If yes, please specify:			Conduct disorder?		
Gastrointestinal:			Oppositional defiant disorder?		
Acid reflux (GERD)?			Obsessive-compulsive disorder?		
Constipation?			Other psychiatric disorder?		
Fecal accidents (of stool)			If yes, specify type:		
Feeding problems?			Development:		Give Age
Genitourinary:			Age that child first smiled socially?		
Daytime urinary accidents?			Age that child rolled over?		
Bedwetting after age 6?			Age that child first walked?		
Urinary tract infections?			Age that child first spoke?		
Abnormal puberty?			Age that child first spoke in sentences?		
If yes, please specify:			Any regression or loss of milestones? Circle: No / Yes		
			If yes, age that regression began		

School History:

1. What is your child's grade level? _____
2. What school does your child attend? _____
3. How is your child's performance in school (i.e. grades/scores)? *Circle appropriate answer below:*
Poor, below average, average, above average, excellent.
4. How is your child's performance on standardized tests? *Circle appropriate answer below:*
Poor, below average, average, above average, excellent.
5. How does your child's performance compare to your expectations? *Circle appropriate answer below:*
Poor, below expectations, as expected, above expectations, exceeds all expectations.
6. Does your child have a known learning disability? *Circle yes or no.* If yes, please specify the learning disability, including date(s) of diagnosis and evaluation and management plan: _____

7. Are you concerned that your child may have a learning disability? *Circle yes or no.* If yes, please specify the area of concern: _____

8. Has your child been penalized with any of the following (Circle one):
detention / suspension / expulsion / none of these
9. Has your child had any psychoeducational testing? *Circle yes or no.* If so, specify findings in brief: _____

10. Does your child have an IEP in place? *Circle yes or no*
11. Does your child have a 504 plan in place? *Circle yes or no*
12. If yes to question 11 or question 12, please provide or attach a copy of current IEP and/or 504 plan.

Stress History (of child and immediate family):

1. Is there a stress in the family of any type (emotional, marital, financial, etc)? *Circle yes or no*
2. Is the child cared for primarily by a *parent* or a *legal guardian* (*circle appropriate answer*)?
If legal guardian, what is the legal guardian's name and relationship to the child? _____
3. For separated or divorced families, who has custody? _____.
Please provide details of custody arrangement and a copy of custody papers: _____

4. Is there any stress in the parents' relationship with each other (regardless of marital status)? *Circle yes or no*
5. If the parents are divorced/separated, is there any stress between a parent and a significant other?
Circle yes or no.
6. In general for the parents or legal guardian, has there been any significant tension or stress? *Circle yes or no*
7. Has the child witnessed any violence? *Circle yes or no.* If yes, please describe briefly: _____

8. Is there any current substance abuse (alcohol or drugs) in a family member? *Circle yes or no*
9. Are there problematic relationships in or with the immediate family at this time? *Circle yes or no*
10. Regarding the child, are there any bullying concerns? *Circle yes or no.*
If yes, is your child the *bully* or the *victim* (*circle all that apply*).
11. As far as you know, are there any peer pressures for your child? *Circle yes or no.* If yes, please explain:

12. As far as you know, are there any social pressures for your child? *Circle yes or no.* If yes, please explain:

13. Has this/your child ever used mind-altering substances (drugs, alcohol, cigarettes, other person's prescription drug)? *Circle yes or no.* If yes, please explain:

Family History	No	Yes	
<i>Does any family member have any of the following:</i>			<i>Relationship to child (like "paternal aunt" for father's sister)</i>
Prescription drug use by parent?			
If so, list medications			
Restless leg syndrome?			
Periodic limb movement disorder?			
Arrhythmia (abnormal heart rhythm or heart beat)?			
Sudden death at age <35 years?			
Unexplained death at age <35 years?			
Death by drowning?			
Death at a young age (<35 years)?			
Sudden heart attack or cardiac death in a young person?			
Sudden death during exercise?			
Cardiomyopathy (floppy or poorly functioning heart)?			
If so, what type?			
Hypertrophic cardiomyopathy?			
Wolf-Parkinson White Syndrome (WPW)?			
Prolonged QT syndrome?			
Short QT syndrome?			
Brugada syndrome?			
Marfan syndrome?			
Medical syndrome?			
If medical syndrome, what type?			
Developmental delay?			
Autism?			
Autistic spectrum disorder?			
Asperger's syndrome?			
Pervasive developmental disorder?			
Sensory processing/integration disorder?			
Cognitive limitations?			
Mental retardation?			
Learning disability?			
ADHD?			
ADD?			
School or academic problems?			
If yes, what type?			
Mood disorder (like depression)?			
Bipolar disorder?			
Anxiety disorder?			
Other mental health problem or mental illness?			
If so, what type?			
Traffic violations?			
Encounters/problems with the law?			
Incarcerations/jailings?			
Tobacco use by parent?			
Alcohol use by parent?			
Substance use by parent?			
Illegal drug use by parent?			

Review of Systems	No	Yes
Does your child ever complain of chest pain with exercise?		
Does your child ever complain of shortness of breath with exercise?		
Has your child ever fainted (syncope)?		
Does your child experience dizziness or near-fainting?		
Has your child ever fainted or near-fainted with exercise?		
Have you noticed a change in your child's exercise tolerance?		
If so, what is the reason for change in exercise tolerance?		
Has your child ever complained of palpitations (abnormal or fast heart beat)?		
Has your child ever complained of extra or skipped heart beats?		
Has your child ever had a seizure?		
If so, what type?		
Does your child have tics (makes movements/sounds without knowing) ?		
Does your child frequently snore?		
Does your child have sleep apnea (long pause without breathing)?		
Does your child have restless sleep?		
Does your child have daytime sleepiness?		
Does your child have excessive leg movement during sleep?		
Does your child have a problem going to sleep?		
Does your child have problem staying asleep?		
Does your child resist bedtime?		
Does it take a long time for your child to fall asleep?		
Does your child have nighttime awakenings?		
Does your child have early morning awakenings?		
Does your child have sleep walking?		
Does your child have variable/inconsistent bedtimes?		
Does your child have variable/inconsistent wakeup times?		
Does your child have bedtime routine in place?		
Does your child have electronics in the bedroom?		
Does your child drink/use caffeine?		
What is your child's bedtime?		
What is your child's wakeup time?		
Does your child have mood swings?		
Does your child display disruptive behavior at home or school		
Does your child worry a lot (anxiety)?		
Has your child ever seemed depressed?		
Has your child ever expressed suicidal thoughts, threats or actions?		
Does your child have delusions (believe things that are not real)?		
Does your child smoke cigarettes?		
Does your child use tobacco?		
Does your child drink alcohol?		
Does your child use illegal drugs?		
Does your child use someone else's prescription drugs?		
Does your child have learning difficulties		
Does your child lead exposure?		
Does your child use computer, TV or video game system >2 hours/day?		
Does your child play video games with violent content?		
Does your child watch media/movies rated for older children?		