Medical History Form | Pre-school

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(Please complete form as best you can)

Today's Date: _____

IDENTIFYING INFORMATION:

Child's Name: _____

Date of Birth: _____ Age: _____ Yrs. _____ Mos. _____ Sex: M F

School: _____ Grade: _____

Parent Names: _____

Stepparents Involved: _____

Child lives with: _____

Other family members (list ages and in/out of home):

Biological siblings: _____

Step Siblings: _____

Others: _____

Primary language spoken in home: _____

REASON FOR REFERRAL:

Referred by: _____

Reason for visit: _____

When was the reason first noticed? _____ By whom? _____

Previous diagnosis (list type and dates): _____

Previous evaluations (list type and dates): _____

Current/previous treatment (list type and dates): _____

What are your concerns about your child? _____

What do you hope will be gained by having your child seen at this clinic? _____

Medical Contacts:

Pediatrician: Group or practice:

Other physicians or therapists:

Name: Group or practice:

Name: Group or practice:

Name: Group or practice:

Pregnancy/Birth History:

For children three and under please complete all information below.
For children three and older please record any notable information.

Medical care was begun during which month of pregnancy:

Length of pregnancy (in weeks):

Length of hospital stay:

Birth weight:

Was labor induced? Yes No

Birth Was:

Normal? Yes No Caesarean? Yes No Breech? Yes No Twins or More? Yes No

Were forceps/vacuum extractor used? Yes No

Did mother have complications? Yes No

If yes, specify:

PREGNANCY/BIRTH HISTORY (continued):

Did baby need medical assistance in starting to breathe? Yes No

If so, how long before normal breathing was established?

What means were used to establish normal breathing?

APGAR:

At 1 min. At 5 mins.

Was baby in incubator? Yes No If so, for how long?

CHILDHOOD MEDICAL HISTORY:

Check any of the following that apply. List age and explanation:

Item	✓	Age	Explanation
Regular medication (please list)			
Convulsions/seizures			
Meningitis			
Encephalitis			
Injury to head			
Fainting spells			
Measles			
Chronic illnesses			
Constipation			
Reflux			
Allergies			
Chronic cough			
Asthma			
Heart disorders			
Stomach or intestinal disorders			
Reactions to immunizations (specify)			
Chronic ear infections			
Hearing exam/poor hearing			
Vision exam/poor eyesight			
Hospitalizations (give details)			
Other			

FAMILY HISTORY:

Check any of the following that apply. List relationship (i.e. mother, brother) and explanation:

Family history of…	✓	Relationship	Explanation
Learning disorders			
Emotional disorders			
Genetic disorders			
Attention disorders			
Speech/language disorders			
Substance abuse			
Other			

MOTOR DEVELOPMENT: *(Just do the best you can)*

Check any that apply. List age that your child achieved this skill:

Skill	✓	Age	Skill	✓	Age
Smiled			Bowel trained		
Followed with eyes			Went to bathroom alone		
Reached for objects			Undressed himself/herself		
Rolled over			Dressed himself/herself		
Sat without support			Used buttons, zippers, and snaps		
Crawled			Skipped		
Pulled to stand			Rode tricycle		
Stood without support			Used eating utensils		
Walked alone			Used writing tools		
Bladder trained			Used scissors		

SPEECH AND LANGUAGE DEVELOPMENT:

Check any of the following that apply:

My child communicates by…	✓	My child communicates by…	✓
Gestures		Single words	
Eye gaze		Phrases	
Crying		Conversation	
Sign language		Augmentative device	

Describe VERBAL BEHAVIOR:

Can you understand your child's speech? Yes No Can others? Yes No
If yes, describe:

Estimate vocabulary size: 0 words 1-25 words 25-50 words 50-100 words over 100 words

Describe LISTENING BEHAVIOR:

Can your child follow directions? Yes No
Can your child answer simple questions? Yes No

EATING/SWALLOWING BEHAVIORS:

Describe typical foods/liquids consumed at:

Breakfast:

Lunch:

Dinner:

Quantity of liquids consumed per day:

What does your child drink from? (bottle, sippy cup, cup, etc.)

How does your child eat? (spoon-fed, finger foods, spoon, adaptive equipment)

Does your child have a good appetite? Yes No
Is your child a picky eater? Yes No
Does your child choke frequently? Yes No
Does your child drool? Yes No
Does your child refuse any food tastes, textures, or temperatures? Yes No
If yes, describe:

Does your child suck his/her thumb? Yes No
Does your child suck a pacifier? Yes No

ACADEMIC/EDUCATION DEVELOPMENT:

Pre-school: Phone:
Address:
Days per week: Teacher:

History:

Preschools/schools attended	Years

Check all of the following that apply:

Academic behaviors	✓
Poor physical coordination	
Letter formation	
Poor memory, short-term and long-term	
Right-left confusion, directionality problems	
Reluctance/refusal to use one hand	
Late letter recognition	
Conflict with teacher	
Certified for special education (LD resource help, MR, Speech, etc.)	

SOCIAL/EMOTIONAL BEHAVIORAL DEVELOPMENT:

Who generally disciplines the child?
What methods are used:
Do parents agree on methods of discipline? Yes No
If no, describe:

Check any of the following that apply:

Behaviors	✓	Explanation
Difficulty sleeping ☐ / Nightmares ☐		
Enuresis (wetting) ☐ / Encopresis (soiling) ☐		
Sucks thumb		
Difficult to discipline		
Temper tantrums		
Sad ☐ / Cries easily ☐		
Unusually inactive, fidgety / Bites nails		
Unusually inactive, apathetic		
Difficulty with brothers and/or sisters		
Difficulty in getting along with other children		
Lacks age appropriate play skills		
Avoids peer interactions or other unfamiliar social contacts		
Socially inappropriate		
Does not look where you point		
Does not look to you for reassurance		
Inattentive ☐ / Impulsive ☐ / Distractible ☐		

Anxiety □ / Separation anxiety □		
Difficulty with transitions		
Argumentative		
Destructive		
Self-conscious / easily embarrassed		
Motor and/or vocal tics		
Oddities of speech or motor movement		
Low productivity at school, work, home		
Overly dependent / helpless		
Chronically tired or irritable		
Headaches, stomachaches, nausea		
Odd/bizarre ideas		

Additional comments:

Please note any major changes in your child's family, school, social life in the last 6-9 months, which could be important. If there is any specific information which has not been requested on this form but which would help us in understanding your child's problems, please include here:

Thank you for taking the time to complete this form. It will help us serve your family better. If you have other critical documentation related to your concerns, please bring copies of records to your first appointment.