CHILD HISTORY FORM

Date_____

Child's Name_____ Date of Birth_____

Address_____ Phone_____

City_____ State_____ Zip_____ Sex_____ Race_____

Age_____ Grade_____ School_____

Pediatrician_____

Father's Name_____ Date of Birth_____

Address_____ Home Phone_____

City_____ State_____ Zip_____ Cell Phone_____

Email address_____

Employer_____ Work Phone_____

Employer Address_____ Race_____

Mother's Name_____ Date of Birth_____

Address_____ Home Phone_____

City_____ State_____ Zip_____ Cell Phone_____

Email address_____

Employer_____ Work Phone_____

Employer Address_____ Race_____

Insurance:

Primary Insurance: _____ ID # _____

Secondary Insurance: _____ ID # _____

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_____

Used First Words_____ Combined Words _____ Gave Up Bottle_____

Gave Up: Pacifier_____Thumb Sucking _____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? _____