

Medical History

Patient Name: _____

Date: _____

PREGNANCY/DELIVERY

- Pregnancy Proceeded Without Complications
 With Complications
- | | | |
|---|---|--|
| <input type="checkbox"/> Eclampsia | <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Multiple Births |
| <input type="checkbox"/> Polyhydramnios | <input type="checkbox"/> Positive for Cytomegalovirus CMV | |
| <input type="checkbox"/> Positive for HIV | <input type="checkbox"/> Pre-eclampsia | <input type="checkbox"/> Positive for Herpes |
| <input type="checkbox"/> Premature Labor | <input type="checkbox"/> Positive for Strep B | <input type="checkbox"/> Substance Exposure |
| <input type="checkbox"/> Toxemia | <input type="checkbox"/> Other _____ | |

Length of Pregnancy _____ week's

Prenatal care: Yes No

- Delivery Proceeded Without Complications
 With Complications

- | | | |
|---|---|---|
| <input type="checkbox"/> Abruptio Placenta | <input type="checkbox"/> Breech Presentation | <input type="checkbox"/> Low Birth Weight |
| <input type="checkbox"/> Negative Vacuum | <input type="checkbox"/> Premature Rupture of Membranes | |
| <input type="checkbox"/> Prolapsed Cord | <input type="checkbox"/> Use of Forceps | <input type="checkbox"/> Uterine Rupture |
| <input type="checkbox"/> Placenta Previa | <input type="checkbox"/> Non-progressive/unproductive Labor | |
| <input type="checkbox"/> Occiput Posterior Position | <input type="checkbox"/> Umbilical Cord Wrapped Around Neck | |
| <input type="checkbox"/> Other _____ | | |

Delivery was Vaginal C-Section Emergency C-Section

Length of child's hospital stay _____ Birth Hospital _____

Mothers age at time of child's birth _____

Birth Weight _____ **Birth Height** _____

Additional Comments: _____

Complications Following Birth:

- | | | |
|---|---|--|
| <input type="checkbox"/> Anemia of Prematurity | <input type="checkbox"/> Bronchopulmonary Dysplasia (BPD) | <input type="checkbox"/> Cleft Lip |
| <input type="checkbox"/> Cleft Palate | <input type="checkbox"/> Club Foot | <input type="checkbox"/> Cytomegalovirus |
| <input type="checkbox"/> ECMO | <input type="checkbox"/> Failure to Thrive | <input type="checkbox"/> Hyperbilirubinemia |
| <input type="checkbox"/> IVH Bleed Grade I | <input type="checkbox"/> Intrauterine Growth Retardation (IUGR) | <input type="checkbox"/> IVH Bleed Grade II |
| <input type="checkbox"/> IVH Bleed Grade III | <input type="checkbox"/> IVH Bleed Grade IV | <input type="checkbox"/> Meconium Aspiration |
| <input type="checkbox"/> Necrotizing Enterocolitis (NEC) | <input type="checkbox"/> Jaundice treated by light therapy &/or blanket | |
| <input type="checkbox"/> Neonatal hypoxia | <input type="checkbox"/> Oxygen dependency | <input type="checkbox"/> PDA |
| <input type="checkbox"/> Positive dependency | <input type="checkbox"/> Respiratory Disease Syndrome | <input type="checkbox"/> Respiratory Stridor |
| <input type="checkbox"/> Ventilator Dependency | <input type="checkbox"/> Respiratory Syncytial Virus (RSV) | <input type="checkbox"/> VP Shunt |
| <input type="checkbox"/> Retinopathy of Prematurity (ROP) | <input type="checkbox"/> Thrombocytopenia (Low Platelet Count) | |
| <input type="checkbox"/> OTHER _____ | | |

MEDICAL HISTORY

Does your child have (check all that apply): NONE

- Allergies (list below)
- Autism/Spectrum Disorder
- Cerebral Palsy (CP)
- Colic
- Down Syndrome
- Laryngomalacia
- Periventricular Leukomalacia
- Seizure Condition
- Shunts
- Tube Feeding
- Arteriovenous Malformation (AVM)
- Asthma/respiratory breathing problems
- Cerebral Vascular Accident (CVA)
- Constipation
- Hip Subluxation
- Muscular Dystrophy
- Reflux
- Sleep Disorder/Problems
- Torticollis
- Tubes in ears
- Anoxic brain injury
- Baclofen Pump
- Chronic Ear Infections
- Diarrhea
- Hydrocele
- Osteoporosis
- Scoliosis
- ADD/ADHD
- Traumatic brain injury (TBI)
- Vagal Nerve Stimulator

Other Medical Conditions or Comments: _____

Current Medications: _____

Current Vitamins, Herbs, Minerals, Homeopathic: _____

Allergies: _____

Diagnosed or Suspected Syndromes: _____

Surgeries and Procedures

Type	Date	Results/Details

TESTS

Hearing Test

- Never Tested, No Concerns
- Never Tested, Have Concerns
- Normal Test Result
- Abnormal Test Results

Last Test Date _____

Results/Concerns: _____

Vision Test

- Never Tested, No Concerns
- Never Tested, Have Concerns
- Normal Test Result
- Abnormal Test Results

Last Test Date _____

Results/Concerns: _____

Diagnostic Tests	When	Details/Results
Auditory Brainstem Response		
Biopsy		
Blood Work/ Lab Tests		
Bone Density Scan		
CT Scan		
EEG		
EMG		
Lower GI		
Motility Study/Empty Scan		
MRI		
NCV		
Swallow Study		
Ultrasound		
Upper Endoscopy		
X-Ray		

HOME ENVIRONMENT

Child lives with (check all that applies):

- Birth Mother Birth Father Adoptive Mother Adoptive Father Step-mother
- Step-Father Grandmother Grandfather Siblings _____ (ages)
- Other Relative _____ (specify)
- Legal Guardian _____ (specify)

Adoption: _____ age at adoption

Additional home information: _____

DEVELOPMENTAL HISTORY

Can your child:	What age did this start (list in months):
Bring both hands to mouth	
Button pants/shirt	
Come to sitting from a lying position	
Creep or crawl alone	
Fully toilet trained	
Grab a toy	
Hold head up alone	
Pull self to standing position	
Roll over	
Self-bath	
Self-dress	
Sit alone without support	
Stand unsupported	
Tying shoes	
Walk with support	
Walk unaided	
Zip/unzip clothing	

Hand preference: Right Handed Left Handed Neither

Handwriting concerns: Yes No Describe if yes: _____

DESCRIPTION OF CHILD:

- Active Affectionate Aggressive Calm Cautious Curious Demanding
 Difficult to comfort Distractible Fearful Fearless Fussy Insecure
 Motivated Passive Persistent Playful Shy Stubborn Withdrawn
 OTHER _____

Sensory Processing Concerns: Yes No (if yes we will have you fill out a sensory profile)
 i.e. response to sight, sound, touch

Social Emotional Skills:

- Is easily distracted Prone to emotional outbursts Only plays with adults Calms self easily
 Prefers to play alone Doesn't allow other to join in play Difficulty making friends Plays with peers
 Poor eye contact Gets angry/frustrated easily Aggressive toward others
 Difficulty with separation Other _____

FEEDING**FEEDING MILESTONES**

Milestone	Started when (months)	Milestone	Started when (months)
Use a bottle		Hold own bottle/cup	
Use a pacifier		Use a straw	
Eat baby food		Stop using bottle	
Eat junior food		Stop using pacifier	
Eat table food		Use utensils to eat	
Drink from a cup		Self-feeding	

Breast Feeding:

Number of times breast fed per day _____ Weaned from breast feeding (age) _____

Never breast fed

Feeding Adaptions:

Thickened Liquids Consistency: _____ Calorie Supplements Details: _____

Adapted Utensils Details: _____ Adapted Seating Details: _____

Tube Feeding Amount: _____ Times per day: _____ Continuous Bolus

Describe any feeding problems: _____

Food likes: _____

Food dislikes: _____

SPEECH LANGUAGE**SPEECH MILESTONES**

Milestones	Started when (months)	Milestones	Started when (months)
Babbling		Putting 2 words together	
Saying first words		Using short sentences	
Naming familiar objects			

COMMUNICATION SKILLS

Does the child:	YES	NO
Have speech that is understood by most people		
Respond correctly to yes/no questions		
Follow simple instructions		
Respond when name is called		
Stutter		

Recognize objects, people and places		
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Primary Communication: Verbal Non-Verbal None

Methods of Communication used

- Vocalizations 2 Word Phrases Facial Expressions Manual Sign Language Pointing
 Single Words Complete Sentences Body Languages Gestures Eye Gaze

First Words: _____

Describe any current speech concerns: _____

Augmentative Communication Device: _____

Specialist/Other Services

Service/Specialist	When	How often	Where/Provider Name
Assistive Technology			
Audiology			
Behavior Therapy			
Vision Therapy			
Nutrition			
Occupational Therapy			
Physical Therapy			
Speech Therapy			
Other			

School Services:

Does your child have an IFSP? Yes No

Does your child have an IEP? Yes No

Has your child had a psychological or neuropsychological evaluation completed? Yes No

Grade in school _____ Name of school _____

Additional Comments: _____

