PEDIATRIC DEVELOPMENT & REHABILITATION PROGRAM

CHILD HISTORY INTAKE FORM

Child's Name: ____
Last First Middle

DOB: ________________________ Today's Date: ______________________

Name of person filling out this form: ____

Relationship to Child: ____

Who does the child live with: ____

Please list all your concerns:

1. ____
2. ____
3. ____
4. ____

What do you want to have happen at this evaluation?

____

____

Is your child on any medications? Please list medication and dose:

____

What language(s) do parent(s) speak? ____
What language(s) does child speak? ____

Do you have any cultural or religious preferences that you would like us to know about? ______
____

Are your child's immunizations current? ❑ Yes ❑ No
Does your child have any allergies? ❑Yes ❑No If yes, please list what your child is allergic to:____

During pregnancy, did mother take: Alcohol? ❑ Yes ❑ No Drugs? ❑ Yes ❑ No

Smoke Cigarettes/Tobacco? ❑ Yes ❑ No Medication? ❑ Yes ❑ No

If yes, which medication? ____

Is your child: ❑ Biological ❑ Foster ❑ Adopted If adopted, at what age? ________

❑ Conceived with assisted reproductive technology (ART, IVF)

Labor and Delivery:

Age of mother at delivery: ________ Age of father at delivery: _________

Number of prior pregnancies: _________ Number of prior miscarriages: ___________

Was the child born ❑ Full Term (37-42 weeks) ❑ Premature ____ # of weeks gestation

Was labor induced? ❑ Yes ❑ No

Type of delivery: ❑ Vaginal ❑ Breech ❑ Forceps ❑ Cesarean

Birth weight: ___________ Apgar scores (if known): __________________

Neonatal Intensive Care (NICU) ❑ Yes ❑ No

Did mother experience the "baby blues" (postpartum depressions)? ❑ Yes ❑ No

Any problems during pregnancy, labor, or birth? ______________________________________
____
____

Newborn History:

Did your child pass their newborn hearing screening? ________

When was your child's last hearing and vision test? ___________________________________

List any medical, feeding or developmental problems for your baby?

____
____

Developmental Milestones: Please provide the approximate age when your child accomplished the following milestones (*if you remember*)

Developmental milestone	**Age**	**Developmental milestone**	**Age**
Motor skills		**Language/Communication skills**	
Rolled over		Smiled	
Sat alone		Babbled ("ba-ba-ba")	
Crawled		Said "mama"	
Walked alone		Said "dada"	
Pedaled a tricycle		Responded to his/her name	
Self-Care skills		Used single words	
Finger feeds		Combined 2 words	
Feeds self with spoon		Spoke in sentences	
Ate independently		Followed one simple direction	
Toilet trained during the day		Understood the word "no"	
Dressed alone		Pointed to one body part	
Tied shoe laces alone			

Past History:

Please list any serious illness, surgery, or hospitalizations your child has had:

____

____

Describe any sensitivities your child may have with movement, feel/ touch, or sounds:

____

____

Family History (Mother, Father, Sisters or Brothers):
Do any members of your family have the following problems? Please check

- ❑ Birth defects
- ❑ Genetic disorders
- ❑ Hearing loss
- ❑ Vision impairment
- ❑ Learning disabilities
- ❑ ADHD/ ADD
- ❑ Autism
- ❑ Cerebral palsy
- ❑ Seizures
- ❑ Allergies
- ❑ Mental retardation/Intellectual disability
- ❑ Mental health problems: Anxiety, Depression, Bipolar, OCD, Schizophrenia, Tics

Others ____

School History:
Where does your child attend preschool/ daycare/ school? ______________________________
When? ____
What special school based services does your child receive? ____________________________
____

Therapy History:

Please list past and current types of therapy your child has received:

____

____

Is there anything else you would like us to know about your child?

____

____