





**III. Child's Birth History:** (Please respond to all items)

Were any chemical substances consumed during pregnancy? cigarettes alcohol marijuana other _____		
Were there any concerns during pregnancy, labor, and delivery? If yes, please explain:		
How was your child delivered? vaginal birth cesarean section	How many weeks gestation was your child at birth? _____	
How many days after birth was infant released from the hospital? _____		Infant's weight at birth: _____
Infant's Height at birth: _____	Other Comments:	
<b>Please check all that apply:</b>	Oxygen	incubator
NICU hospitalization # of days _____	problems sucking/feeding	antibiotic treatment
E jaundice biliruben lights or blankets	infantile seizures	other; Please explain

**IV. Developmental History:** If your child has **not acquired** the skills, please print "NA" in the box. **IF CHILD ACHIEVED SKILL ON TIME, WRITE:** WNL Handedness: Right Left

Motor Milestones:	Age Acquired:	Motor Milestones: Continued	Age Acquired:	Speech/Language Milestones:	Age Acquired:
Roll		Get dressed		Smiling	
Sit up unsupported		Pedal a tricycle		Babbling	
Crawl		Pedal a 2 wheeler (no training wheels)		Pointing	
Independent Walking				1st words	
Independent Toileting		Tie shoes		2-3 words paired	

**V. Education History**

<b>Early Intervention? (ages 0-3)</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, check all that apply and indicate how often (i.e., 1 hour/weekly)				
Speech/language therapy How often: _____	Occupational therapy How often: _____	Physical therapy How often: _____	Consultation with "Interventionist" How often: _____	Structured Play/Social Group How often: _____
Please describe any other types of therapies during ages 0-3:				

**Was a multi-factored evaluation completed at age 3?**  YES  NO

If yes, by which school district: \_\_\_\_\_

<b>Preschool (Age 2):</b> special education inclusion setting private community preschool
Did staff relate any concerns to you about your child's development or classroom behavior? If so, please describe:
<b>Preschool (Age 3):</b> special education inclusion setting private community preschool
Did staff relate any concerns to you about your child's development or classroom behavior? If so, please describe:
<b>Preschool (Age 4):</b> special education inclusion setting private community preschool
Did staff relate any concerns to you about your child's development or classroom behavior? If so, please describe:

**Between ages 3 and kindergarten did your child receive any therapies? If so please describe:**

**Elementary School Years:**

Kindergarten:	special education classroom	inclusion setting	regular education
1 <sup>st</sup> grade:	special education classroom	inclusion setting	regular education
2 <sup>nd</sup> grade:	special education classroom	inclusion setting	regular education
3 <sup>rd</sup> grade:	special education classroom	inclusion setting	regular education
4 <sup>th</sup> grade:	special education classroom	inclusion setting	regular education
5 <sup>th</sup> grade:	special education classroom	inclusion setting	regular education
6 <sup>th</sup> grade:	special education classroom	inclusion setting	regular education

Have teachers reported any concerns regarding academic and/or behavioral difficulties? If yes, please explain:

**Middle School Years:**

Have teachers reported any concerns regarding academic and/or behavioral difficulties? If yes, please explain:

**High School Years**

Have teachers reported any concerns regarding academic and/or behavioral difficulties? If yes, please explain:

**VI. Medication History:**

**List current and past medication (OTHER THAN “routine” medications, e.g., antibiotics for ear infections, fever medications, etc)**

Is the child presently on medication?

Name of medication	Prescribed for:	(Helpful, Not Helpful)	Outcome	Unusual reaction
1.				
2.				
3.				

Has the child previously been on medication?

Name of medication	Prescribed for:	(Helpful, Not Helpful)	Outcome	Unusual reaction
1.				
2.				
3.				

Please indicate any drug allergies:

	What problems did the allergy cause?
1.	
2.	

**Please list any alternative therapies, home remedies, dietary supplements:**

**VII. Medical History:**

Has your child had any of the following? If yes, please explain.

<b>Problem:</b>	<b>If yes, please check</b> ✓	<b>Please explain:</b>
Staring spells		
Seizures (with or w/o fever)		
Head trauma		
Headaches		
Speech problems		
Tics or repeated movements		
Weight loss		
Rapid weight gain		
Trouble with appetite		
Unexplained fevers		
Vision problems		
Hearing problems		
Heart problems		
Hay fever/asthma		
Lung problems		
Diarrhea or constipation		
Stomach or bowel problem		
Urinary tract infections		
Kidney problems		
Broken bones or joint problems		
Skin problems		
Birth marks		
Endocrine problems		

Anemia (low blood)		
Immunologic problems		
Immunization reactions		
Other?		
For girls: age at first menstrual period or none:		Regular? Yes No

**VIII. Psychological / Psychiatric / Neurological Evaluation-Treatment History:**

Has your child participated in any assessments/evaluations or received treatment through a private professional, school or other agency? If yes, please list in order:

Name of Professional/Organization:	Purpose:  Diagnosis:	Report available?  Yes No	Date of testing:
Name of Professional/Organization:	Purpose:  Diagnosis:	Report available?  Yes No	Date of testing:
Name of Professional/Organization:	Purpose:  Diagnosis:	Report available?  Yes No	Date of testing:
Name of Professional/Organization:	Purpose:  Diagnosis:	Report available?  Yes No	Date of testing:
Name of Professional/Organization:	Purpose:  Diagnosis:	Report available?  Yes No	Date of testing:

Has your child had any EEG's, CT scan, or MRI scans?

<b>EEG</b>	Yes	No	If yes, when: _____ where: _____ outcome: _____
<b>CT</b>	Yes	No	If yes, when: _____ where: _____ outcome: _____
<b>MRI</b>	Yes	No	If yes, when: _____ where: _____ outcome: _____

**IX. ADAPTIVE FUNCTIONING**

<p><b>SOCIAL SKILLS:</b></p>	<p>Does your child have many friends both in and out of school (i.e. go on play dates, etc.)?  <input type="checkbox"/> YES <input type="checkbox"/> NO If no, please explain:</p> <p>Does your child communicate effectively with others both verbal and non-verbal (i.e. makes good eye contact, etc.)?  <input type="checkbox"/> YES <input type="checkbox"/> NO If no, please explain:</p> <p>Does your child interact appropriately with others in terms of give and take, having empathy, and not behaving aggressively?  <input type="checkbox"/> YES <input type="checkbox"/> NO If no, please explain:</p>	<p>AREA OF COCNERN:</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p>
<p><b>SELF-CARE NEEDS:</b></p>	<p>Is your child able to take care of his or her basic self-care needs for his or her developmental level, such as brushing teeth, cleaning room, doing basic chores?  <input type="checkbox"/> YES <input type="checkbox"/> NO If no, please explain:</p> <p>When it comes to organizing his or her room or personal space, is your child capable of this for his or her developmental level?  <input type="checkbox"/> YES <input type="checkbox"/> NO If no, please explain:</p>	<p>AREA OF COCNERN:</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p>
<p><b>ORGANIZATION</b></p>	<p>Does your child complete homework independently?  <input type="checkbox"/> YES <input type="checkbox"/> NO If no, please explain:</p> <p>When it comes to organizing work space, such as a desk or backpack, or completing home work on time, does your child have difficulty?  <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, please explain:</p>	<p>AREA OF COCNERN:</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p>

***Thank you for completing the form.  
This information will assist in the providing the best care for your child.***