



Date: _____

Family History			
Full Legal Name Last Name	First Name	Middle	<input type="checkbox"/> M <input type="checkbox"/> F
Mothers Name:		Occupation:	
Fathers Name:		Occupation:	
Marital Status:			
Siblings		Age	Sex
			<input type="checkbox"/> M <input type="checkbox"/> F
			<input type="checkbox"/> M <input type="checkbox"/> F
			<input type="checkbox"/> M <input type="checkbox"/> F
			<input type="checkbox"/> M <input type="checkbox"/> F
Birth History			
Length of pregnancy: <input type="checkbox"/> Full Term <input type="checkbox"/> Premature <input type="checkbox"/> Late		Delivery: <input type="checkbox"/> Normal <input type="checkbox"/> Cesarean	
Birth Weight:	Where there concerns for this child at this time: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Dental visit:	Immunization current?		
Developmental History			
Approximate age child was able to do the following behaviors:			
Sit alone:	Crawl:	Stand Alone:	Walk Alone:
Say first words:	Use Sentences:	Toilet Trained:	
Major Illnesses? (Chicken pox, mumps, polio, etc.)			
History of ear infections? <input type="checkbox"/> Yes <input type="checkbox"/> No		Number of ear infections in the past year _____	
Tubes inserted? <input type="checkbox"/> Yes <input type="checkbox"/> No		When?	
General behaviors shown at home:			
<input type="checkbox"/> High Activity Level	<input type="checkbox"/> Short Attention Span	<input type="checkbox"/> Poor Self-Control	<input type="checkbox"/> Low Frustration Level
<input type="checkbox"/> Temper Tantrums	<input type="checkbox"/> Interrupts Frequently	<input type="checkbox"/> Doesn't Listen When Spoken to	<input type="checkbox"/> Stubborn
<input type="checkbox"/> Doesn't Learn From Experience	<input type="checkbox"/> Sudden Outburst of Physical Abuse to other Children		
Parent's description of reason for referral?			
Has this condition progressed in the past year?			
Preschool(s) attended? When? Where?			
How does your child spend their day?			