CHILD NEUROPSYCHOLOGICAL HISTORY

Child's Name_____

Address (Street, City, ST, Zip)_____

Parent or guardian phone: (H)_____ (W)_____

Age_____ Birthdate_____ Religion_____

Sex_____ Ethnic or Racial Background_____

Grade and School_____

Special Placement (if any)_____

Hand child uses for writing or drawing: Right_____ Left_____ Switches between them_____

Primary Language _____ Secondary Language_____

Hand used for writing: (check one) Right hand_____ Left Hand_____

Medical diagnosis: (1) _____

(2) _____

(3) _____

(4)_____

Who referred the child for this testing?_____

Briefly describe the problem(s):

(1) _____

(2) _____

(3) _____

(4) _____

What specific questions would you like answered by this evaluation?

(1) _____

(2) _____

(3) _____

(4) _____

THIS FORM HAS BEEN COMPLETED BY:

Name_____ Relationship to child_____

Address_____

Phone (H)_____ (W)_____

SYMPTOM SURVEY

For each symptom that applies to the child, place a check in the box. Compare the child to other children of the same age. Then, check if this is a NEW symptom (within the past year) OR after the injury/illness or an OLD symptom (over one year OR before the injury or illness). Add any comments next to the item.

1) PROBLEM SOLVING

✓	New	Old	
☐	___	___	Difficulty figuring out how to do new things
☐	_____	_____	Difficulty making decisions
☐	_____	_____	Difficulty planning ahead
☐	_____	_____	Difficulty solving problems a younger child can do
☐	_____	_____	Disorganized in his/her approach to problems
☐	_____	_____	Difficulty understanding explanations
☐	_____	_____	Difficulty doing things in the right order (sequencing)
☐	_____	_____	Difficulty verbally describing the steps involved in doing something
☐	_____	_____	Difficulty completing an activity in a reasonable period of time
☐	_____	_____	Difficulty changing a plan or activity when necessary
☐	_____	_____	Is slow to learn new things
☐	_____	_____	Difficulty switching from one activity to another activity
☐	_____	_____	Easily frustrated
☐	_____	_____	Other problem solving difficulties_____

2) SPEECH, LANGUAGE, AND MATH SKILLS

✓	New	Old	
☐	___	___	Difficulty speaking clearly
☐	_____	_____	Difficulty finding the right word to say
☐	_____	_____	Not talking
☐	_____	_____	Rambles on and on without saying much
☐	_____	_____	Jumps from topic to topic
☐	_____	_____	Odd or unusual language or vocal sounds
☐	_____	_____	Difficulty understanding what others are saying
☐	_____	_____	Difficulty understanding what he/she is reading
☐	_____	_____	Difficulty writing letters or words
☐	_____	_____	Difficulty reading letters or words
☐	_____	_____	Difficulty with spelling
☐	_____	_____	Difficulty with math
☐	_____	_____	Other speech, language or math problems:_____

3) SPATIAL SKILLS

✓	New	Old	
☐	___	___	Confusion telling right from left
☐	_____	_____	Has difficulty with puzzles, Legos, blocks or similar games
☐	_____	_____	Problems drawing or copying
☐	___	___	Does not know his/her colors
☐	_____	_____	Difficulty dressing (not due to physical disability)
☐	_____	_____	Problems finding his/her way around placed he/she has been to before
☐	___	___	Difficulty recognizing objects
☐	_____	_____	Seems unable to recognize facial or body expressions of disapproval or emotions
☐	_____	_____	Gets lost easily
☐	_____	_____	Other spatial problems

4) AWARENESS AND CONCENTRATION

✓	New	Old	
☐	_____	_____	Easily distracted by: Sounds_____ Sights_____ Physical sensations_____
☐	_____	_____	Mind appears to go blank at times
☐	_____	_____	Loses train of thought
☐	_____	_____	Difficulty concentrating on what other say but can sit in front of a TV for long periods
☐	_____	_____	Attention starts out OK but cannot keep it up
☐	_____	_____	Other attention or concentration problems:_____

5) MEMORY

✓	New	Old	
☐	_____	_____	Forgets where he/she leaves things
☐	_____	_____	Forgets things that happened recently (e.g., last meal)
☐	_____	_____	Forgets things that happened days/weeks ago
☐	_____	_____	Forgets what he/she is supposed to be doing
☐	_____	_____	Forgets names more than most people do
☐	_____	_____	Forgets instructions
☐	_____	_____	Other memory problems:_____

6) MOTOR AND COORDINATION

✓	New	Old		Check the side this occurs on: Right	Left	Both Sides
☐	_____	_____	Poor fine motor skills (e.g., using a pencil or crayon)	_____	_____	_____
☐	_____	_____	Clumsy	_____	_____	_____
☐	_____	_____	Weakness	_____	_____	_____

☐	_____	_____	Tremor	_____	_____	_____
☐	_____	_____	Muscles are tight or spastic	_____	_____	_____
☐	_____	_____	Odd movements (posturing, peculiar head movements)	_____	_____	_____
☐	_____	_____	Drops things more than most children			
☐	_____	_____	Has an unusual walk			
☐	_____	_____	Problems running			
☐	_____	_____	Balance problems			
☐	_____	_____	Other motor or coordination problems:_____			

7) SENSORY

✓	New	Old		Check the side this occurs on: Right	Left	Both Sides
☐	_____	_____	Needs to squint or move closer to the page to read	_____	_____	_____
☐	_____	_____	Problems seeing objects	_____	_____	_____
☐	_____	_____	Loss of feeling			
☐	_____	_____	Problems hearing sounds			
☐	_____	_____	Difficulty telling hot from cold			
☐	_____	_____	Difficulty smelling odors			
☐	_____	_____	Difficulty tasting food			
☐	_____	_____	Overly sensitive to: Touch_____ Light_____ Noise_____			
☐	_____	_____	Other sensory problems:_____			

8) PHYSICAL

✓	New	Old		How Often?
☐	___	___	Frequently complains of headaches or nausea	_____
☐	_____	_____	Has dizzy spells	_____
☐	_____	_____	Has pain in joints. *Where?*_____	_____
☐	_____	_____	Excessive tiredness	
☐	_____	_____	Frequent urination or drinking	
☐	_____	_____	Other physical problems:_____	

9) BEHAVIOR

✓	New	Old	
☐	___	___	Aggressive
☐	_____	_____	Attached to things, not people
☐	_____	_____	Bedwetting
☐	___	___	Bizarre behavior
☐	_____	_____	Bowel movements in underwear

☐ _____ _____ Dependent

☐ ___ ___ Depressed

☐ _____ _____ Eating habits are poor

☐ ___ ___ Emotional

☐ _____ _____ Fearful

☐ _____ _____ Immature

☐ ___ ___ Nervous

☐ _____ _____ Nightmares, night terrors, sleepwalks

☐ _____ _____ Quiet

☐ ___ ___ Resists change

☐ _____ _____ Risk-taking

☐ ___ ___ Self-mutilates

☐ _____ _____ Self-stimulates

☐ _____ _____ Shy and withdrawn

☐ ___ ___ Sleeping habits are poor

☐ _____ _____ Swears a lot

☐ _____ _____ Unmotivated

☐ ___ ___ Other unusual behavior_____

Below, check all the descriptions of the child that have been present for at least the past 6 months. These behaviors should occur more frequently than other children of the same age.

_____ Careless
_____ Is easily distracted
_____ Has a hard time concentrating for long periods
_____ Rarely follows others' instructions
_____ Does not listen to other people
_____ Goes from one activity to another without finishing anything
_____ Seems like he/she frequently is losing things that are needed for school
_____ Forgetful in daily activities
_____ Seems disorganized
_____ Is very fidgety
_____ Cannot remain seated
_____ Cannot wait for his/her turn when playing with others
_____ Answers before he/she hears the whole question
_____ Frequently makes noise when playing
_____ Seems like he/she is always talking
_____ Is often rude or interrupts others
_____ Seems like driven by a motor

_____ Cannot seem to play quietly
_____ Frequently does dangerous things without considering the consequences
_____ Loses temper easily
_____ Argues with adults
_____ Refuses to comply with requests
_____ Easily blames others for mistakes and problems
_____ Easily annoyed or irritated
_____ Seems angry and resentful
_____ Steals things without people knowing on several occasions
_____ Often runs away form his parents' home and stays away overnight
_____ Easily lies to others
_____ Fire setting
_____ Does not go to school
_____ Breaks into other people's property
_____ Destroys other people's property in some manner other than by fire
_____ Is cruel to animals
_____ Has forcible sexual relations with others
_____ When fighting, has used a weapon on more than one occasion
_____ Starts fights with others
_____ Will steal directly from people
_____ Is cruel to other people

10) Overall, the child's symptoms have developed: _____ Slowly _____ Quickly
11) The symptoms occur: _____ Occasionally _____ Often
12) Over the past 6 months, the symptoms have: _____ Stayed about the same _____ Worsened

PREGNANCY

13) Mother's age at birth:_____ Father's age at birth:_____
14) **Before** the pregnancy, what medications (prescribed or over-the-counter) did the mother take?
List all medications used:_____
15) **While** pregnant, what medications (prescribed or over-the-counter) did the mother take?
List all medications used:_____
16) How often did the mother see her doctor during the pregnancy?
Regularly (as scheduled by the doctor)_____ Rarely_____ Not at all_____
17) During the pregnancy, which of the following did the mother use?

	Amount and Daily Frequency
_____ Alcohol	_____
_____ Caffeine (coffee, colas, etc.)	_____
_____ Marijuana	_____
_____ Recreational drugs (cocaine, heroin, etc.)	_____
_____ Tobacco	_____

18) During pregnancy, the mother's diet was: Good_____ Poor_____
If poor, explain:_____
19) The mother's general physical health during the pregnancy was: Good_____ Poor_____
If poor, explain:_____
20) About how much weight did the mother gain while she was pregnant? _____lbs.

21) During this pregnancy, check all the mother had:

_____ Accident
_____ Anemia
_____ Bleeding (severe or frequent spotting)
_____ Diabetes
_____ High blood pressure
_____ Illnesses or infections
_____ Preeclampsia, eclampsia or toxemia
_____ Psychological problems
_____ Surgery
_____ Vomiting (severe or frequent)

22) How many pregnancies did the mother have prior to this one?

Number of live births: _____
Number of miscarriages: _____
Number of abortions: _____

BIRTH

23) Was the child born:

Early _____ How early? _____ weeks
On time _____ (38-42 weeks)
Late _____ How late? _____ weeks

24) How much did the baby weigh at birth? _____lbs. _____ oz. OR _____gms.

25) How long did the labor last? _____

26) The labor was: Easy _____ Moderately difficult _____ Very difficult _____

27) What type of medication was the mother given to help with delivery? None_____

Demerol_____ Gas_____ Regional nerve (spinal) block_____ Tranquilizer_____ Epidural_____

28) Were forceps used during delivery? Yes_____ No_____

29) Was the baby born:

Head first _____ Transverse (crosswise) _____ Posterior first _____
Breech birth _____ Cesarean section _____ Vacuum extraction _____
Other:_____

30) Did the baby experience any of these problems?

Fetal distress_____ Low placenta (Placenta previa) _____ Prolapsed cord _____
Premature separation of the placenta (Abruptio placenta) _____

31) Describe any other special problems the mother or child had during delivery: _____
_____
_____

32) At birth, did the baby:

Have difficulty breathing? Yes_____ No_____
Fail to cry? Yes_____ No_____
Appear inactive? Yes_____ No_____

33) List the baby's Apgar scores: 1st_____ 2nd_____

34) If the father or mother noticed anything unusual when they first saw the baby, describe:_____
_____

_____

35) If the baby was born with any problems (congenital defects, large or small head, blue baby, bleeding in brain, etc.), describe:_____

_____

36) Describe any special problems that the baby had in the first few days or weeks following birth: _____

_____

_____

37) Describe any special care, treatment, or equipment the child was given after birth: _____

_____

_____

38) How long did the baby stay in the hospital?_____

DEVELOPMENTAL HISTORY

39) For each area, indicate the child's development by circling one description. The "Average" period is only a rough idea of what is average since every developmental milestone actually involves a range of several months (e.g., walking occurs approximately 9-18 months of age). Circle "Early" or "Late" only if you are sure the child's development was different from that of most other children.

GROSS MOTOR SKILLS

Crawled	Early	Average (6-9 months)	Late
Walked alone (2-3 steps)	Early	Average 9-18 months)	Late
Pedals a tricycle	Early	Average 26-32 months)	Late

LANGUAGAE

Followed simple commands	Early	Average 12-18 months	Late
Used single word	Early	Average 12-24 months	Late
Said phrases	Early	Average 24-36 months	Late
Names primary colors	Early	Average 36-48 months	Late

ADAPTIVE

Toilet trained	Early	Average 13-36 months	Late
Feeds self with spoon	Early	Average 21-24 months	Late
Takes off opens shirt/coat	Early	Average 18-24 months	Late

40) List any other significant developmental problems: _____

_____

_____

41) Overall, the child's development was:

Early_____ Average_____ Late_____

42) As an infant or toddler, did the child have poor muscle control (i.e., weakness) of the:

Neck_____ Trunk_____ Legs_____ Arms_____

43) As an infant or toddler, did the child's muscles seem to be unusually tight or stiff?

Yes_____ No_____ If yes, describe:_____

44) Toilet training was: Easy_____ Difficult_____

45) As an infant, to a significant degree, were any of the following present during the first two years of life?

Did not enjoy cuddling _____

Was not calmed by being held or stroked _____

Difficult to comfort _____
Colic _____
Excessive restlessness _____
Poor sleep _____
Head banging _____
Difficult nursing _____

46) Please rate the following behaviors as your child appeared during infancy and toddlerhood:

Activity Level – How active has your child been from an early age? _____

_____

Distractibility – How well did you child pay attention?_____

_____

Adaptability – How well did your child deal with transition and change?_____

_____

Approach/Withdrawal – How well did your child respond to new things (i.e., people and places)?

_____

Mood – What was your child's basic mood? _____

Regularity – How predictable was your child in patterns of sleep, appetite, routines, etc? _____

_____

HEALTH HISTORY

47) Did the child have a good appetite as a baby? Yes_____ No_____

48) Did the child fail to gain weight steadily as a baby? Yes_____ No_____

49) List the baby's illness or physical problems during the first year: _____

_____

50) Has the child had a temperature of 104°F (40°C) or higher for more than a few hours? Yes_____ No_____

If yes, at what age(s)?_____ How long did it last?_____

51) Has the child ever been hit hard on the head or suffered a head injury? Yes_____ No_____

If yes, what age(s)?_____ Did the child lose consciousness? Yes_____ No_____

How did it happen?_____

What problems did the child have (physical or mental) afterward?_____

_____

52) Has the child been diagnosed with seizures or epilepsy?

If yes, which type? Partial seizure_____ Generalized seizure_____ Unclassified type_____

If medication is used, what medication(s)?_____

Has the child ever had a bad reaction to this medicine? Yes_____ No_____

If yes, describe:_____

Did the child ever have a seizure due to a fever or unknown cause? Yes_____ No_____

If yes, describe (age, nature of seizure)_____

53) Was the child ever in the hospital for an accident, injury or operation? Yes_____ No_____

If yes, what age(s)_____ What happened?_____

_____

_____

54) Has the child lever swallowed any poison, non-food, or drug accidentally? Yes_____ No_____

If yes, what age(s)?_____ What happened?_____

55) Did the child have frequent ear infections? Yes_____ No_____

If yes, what age(s)?_____ How often and how severe?_____

What treatment was provided?_____

56) Please check all the following diseases or conditions the child has ever had:

_____ Allergies	_____ Cerebral Palsy	_____ Jaundice	_____ Mumps
_____ Anemia	_____ Chicken Pox	_____ Kidney disorder	_____ Oxygen deprivation
_____ Asthma	_____ Colds (excessive)	_____ Leukemia	_____ Pneumonia
_____ Bleeding disorder	_____ Diabetes	_____ Liver disorder	_____ Rheumatic fever
_____ Blood disorder	_____ Encephalitis	_____ Lung disorder	_____ Scarlet fever
_____ Brain disorder	_____ Enzyme deficiency	_____ Measles	_____ Tuberculosis
_____ Broken bones	_____ Genetic disorder	_____ Meningitis	_____ Venereal disease
_____ Cancer	_____ Heart disorder	_____ Metabolic disorder	_____ Whooping cough

_____ Eye problems _____ Tics (eye blinking, sniffing, and repetitive movement)

_____ Other problems:_____

57) As the child has been growing up, he/she has been sick:

_____Much of the time _____An average amount _____Not much at all

58) List all of the medications the child takes now:

Medication	Dosage	How often?	What for?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

59) Does the child?

Wear glasses Yes_____ No_____ Farsighted_____ Nearsighted_____ Other_____

Use a hearing aid Yes_____ No_____

60) Within the past year has the child had: RESULTS

A vision test? Yes_____ No_____ _____

A hearing test? Yes_____ No_____ _____

61) What is the child's: Height_____ ft. _____ in. Weight:_____ lbs.

62) When was the child's last medical checkup? _____

63) What therapies have been provided to the child? _____ No therapies

_____ Occupational therapy

_____ Physical therapy

_____ Psychological therapy, counseling, or cognitive rehabilitation

_____ Speech therapy

_____ Other therapy_____

FAMILY HISTORY

64) The child lives with:

_____ Biological parent(s) only _____ Relatives _____ Foster parents

_____ Biological parent and other _____ Adoptive parents _____ Institutional care

_____ Other placement_____

Please list all the people currently living in the home with the child and their relation to the child (include family and Non-family members)_____

_____

_____

65) The family income is:

_____ Under $10,000 _____ $10,000-29,999 _____ $30,000-50,000 _____ over $50,000

66) What is the name of the child's biological mother?_____

a. Is she living? Yes_____ No_____ If deceased, explain_____

b. Her age? _____

c. What is her level of education?_____

d. Her occupation?_____

If mother works outside the home, how many hours and what days?_____

e. Does she live in the same house as the child? Yes_____ No_____

f. How often does she see the child?_____

g. How involved is the mother in the child's upbringing? Very____ Somewhat_____ Not at all_____

h. During school, did the mother have:

Learning problems_____

Attention problems_____

Behavior problems_____

Medical problems_____

i. What are the mother's hobbies?_____

j. What is mother's primary language?_____ Secondary language?_____

67) What is the name of the child's biological father?_____

a. Is he living? Yes_____ No_____ If deceased, explain_____

b. His age? _____

c. What is his level of education?_____

d. His occupation?_____

If father works outside the home, how many hours and what days?_____

e. Does he live in the same house as the child? Yes_____ No_____

f. How often does he see the child?_____

g. How involved is the father in the child's upbringing? Very____ Somewhat_____ Not at all_____

h. During school, did the father have:

Learning problems_____

Attention problems_____

Behavior problems_____

Medical problems_____

i. What are the father's hobbies?_____

j. What is father's primary language?_____ Secondary language?_____

68) Please list the names, ages and grade (or job) of the child's brother and sisters:

Name	Age	Grade or Job	Medical, social, school problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

69) Has anyone in the child's biological family (including parents, grandparents, siblings, aunts, and uncles) ever had any of the following?

	Which relative	Describe the problem briefly
_____ Brain disease	_____	_____
_____ Developmental delay	_____	_____

_____ Epilepsy or seizures _____ _____

_____ Learning disability _____ _____

_____ Mental retardation _____ _____ _____

_____ Neurologic disease _____ _____ _____

_____ Psychological problems _____ _____ _____

_____ Reading/spelling difficulty _____ _____

_____ Speech/Language problems _____ _____

70) Which of the child's biological relatives are left handed? No one_____
Mother_____ Father_____ Sibling(s)_____ Grandparents_____

71) What languages are spoken in the home? (List in order of the most frequent first)
(1) _____ (2)_____

72) How is the child disciplined?_____
_____
Is the discipline effective?_____

73) List the child's usual recreational activities and hobbies:_____
_____
_____

74) Have there been any major family stresses or changes in the past year (e.g., moving with a change of school, divorce, significant illness, etc.)? Yes_____ No_____
If yes, explain:_____
_____
_____

75) Does the child attend daycare outside the home or does someone come into the home to provide the service? ___
_____
Does daycare provide any type of formal program of play, developmental, or academic activities? _____
_____
_____

PEER RELATIONSHIPS

76) Does your child seek friendships with peers?_____
_____

77) Is your child sought by peers for friendship?_____
_____

78) Does your child play with children primarily his or her own age? _____
Younger?_____ Older?_____

79) Describe any problems your child may have with peers:_____
_____

SCHOOL HISTORY:

80) The child's present school is: Name:_____
Address:_____
Phone:_____ Contact person:_____

81) Was the child ever held back to repeat a grade? Yes_____ No_____
If yes, which grade?_____ Why?_____
_____

82) Has the child ever been in a special class or provided with special services (e.g., RSP, self-contained day class, learning or language disability class, etc)? Yes_____ No_____
If yes, describe the special class:_____
_____
Is the child in this class or receiving special classes now? Yes_____ No_____
If yes, describe the present class placement:_____
_____

83) Does the child like school? Most of the time_____ Sometimes_____ Almost never_____

84) Does the child:
Have problems with other children in class? Yes_____ No_____
Have problems making friends in school? Yes_____ No_____
Have problems getting along with teachers? Yes_____ No_____
Tend to get sick in the morning before school? Yes_____ No_____

85) Describe the teacher's concerns about the child's schoolwork or behavior:_____
_____
_____

86) What kind of grades has the child received in the past year?
As and Bs_____ Bs and Cs_____ Cs and Ds_____ Ds and Fs_____
Or
Outstanding_____ Good_____ Satisfactory_____ Improvement needed_____ Unsatisfactory_____
Or
Other grading system_____
Are these grades a change from previous years? Yes_____ No_____
If yes, describe:_____
_____

87) In which subject(s) does the child do best?_____
_____

88) Which subject(s) are the most difficult?_____
_____

89) In the past year, how much school has the child missed due to illness or injury?
Less than 2 weeks_____ 2-4 weeks_____ 5-8 weeks_____ Over 8 weeks_____
Briefly describe the reasons if the child has missed a lot of school: _____
_____
_____

90) Does the child seem to have a "school phobia"? Yes_____ No_____
If yes, explain:_____
_____

91) Do you consider your child to understand directions and situations as well as other children his or her age? _____
_____
_____

92) How would you rate your child's overall intelligence compared to other children?
Below average_____ Above average_____ Average_____

PREVIOUS EVALUATIONS

93) Which of these tests or procedures have recently been done? Note if normal or abnormal.

Evaluation	Normal	Abnormal	Date
_____ Blood work	_____	_____	_____
_____ Family physician or pediatrician office visit	_____	_____	_____
_____ Hearing testing	_____	_____	_____
_____ Lead level check	_____	_____	_____
_____ Lumbar puncture or spinal tap	_____	_____	_____
_____ Neurological exam or testing (CT scan, EEG)	_____	_____	_____
_____ Psychological or Neuropsychological Testing	_____	_____	_____
_____ School testing	_____	_____	_____
_____ Speech & Language testing	_____	_____	_____
_____ Vision testing	_____	_____	_____
_____ X-rays	_____	_____	_____
_____ Other tests			
_____	_____	_____	_____
_____	_____	_____	_____

94) What are the names of the physician, psychologist, school authority, or other professionals who are most familiar with the child's problems?

Name_____ Name_____
Address_____ Address_____
_____ _____
Phone_____ Phone_____
Profession_____ Profession_____

Please note: If your child has seen a psychologist at any time in the last year for testing or treatment, please be sure to advise the doctor.

ADDITIONAL COMMENTS: Please note below any further information you feel may be helpful in the evaluation of your child._____
_____
_____
_____
_____
_____
_____

Jack Ayvazian, Ph.D.

PEDIATRIC/ADOLESCENT HEALTH HISTORY INTAKE FORM

Pediatric/Adolescent Health History Intake Form

Last Name:_____First Name:_____Middle Name:_____

Date of Birth:_____Age:_____Sex:_____Today's Date:_____

PRENATAL/BIRTH HISTORY

A. Mother's Pregnancy: Normal Complications:_____
B. Gestation:_____weeks
C. Birth Location: Hospital Birthing Center Home Other_____
D. Delivery: Vaginal C-Section…..Any Complications: No Yes_____
E. Birth Weight:_____lbs_____oz…..Length:_____inches

PRESENT HEALTH CONCERNS: Please list most important health concerns in their order of significance

1._____

2._____

3._____

4._____

PAST MEDICAL HISTORY

MEDICATIONS: Please list prescription medications +/or over the counter medications that you are currently taking, with dosages

1._____ 2._____ 3. _____

4. _____ 5. _____ 6. _____

SUPPLEMENTS: Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages

1._____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

ALLERGIES: Please include mild to severe or life-threatening allergies and reaction (symptoms)

1. Medications:_____

2. Environment:_____

3. Food:_____

Today's Date:_____

PAST MEDICAL HISTORY

CHILDHOOD ILLNESSES: (Circle and indicate age of illness OR mark C for current as it applies to your child)

Acne:	No	Yes/Age_____	Ear Infections:	No	Yes/How often:_____
ADD:	No	Yes/Age_____	Eating Disorders:	No	Yes/Age and type:_____
ADHD:	No	Yes/Age_____	Eczema:	No	Yes/Age:_____
Alcohol use:	No	Yes/How often:_____	Head lice:	No	Yes/Age:_____
Allergies:	No	Yes/Age_____	Molluscum contagiosum:	No	Yes/Age:_____
Asthma:	No	Yes/Age_____	Mononucleosis:	No	Yes/Age:_____
Bedwetting:	No	Yes/Age_____	Obesity/Overweight:	No	Yes/Age:_____
Behavior problems:	No	Yes/Age_____	Pink eye:	No	Yes/Age:_____
Bronchitis	No	Yes/Age_____	Pneumonia:	No	Yes/Age:_____
Colic:	No	Yes/Age_____	Colds:	No	Yes/How often:_____
Constipation:	No	Yes/How often:_____	Sinus Infection:	No	Yes/How often:_____
Cough:	No	Yes/How often:_____	Thrush:	No	Yes/Age:_____
Croup:	No	Yes/Age_____	Vomiting:	No	Yes/Age:_____
Depression	No	Yes/Age_____	Whooping cough:	No	Yes/Age:_____
Diaper rash:	No	Yes/How often:_____	Other:		Age:_____Illness:_____
Diarrhea:	No	Yes/How often:_____	Other:		Age:_____Illness:_____

IMMUNIZATIONS: (Please place an **X** in either the Yes or No box next to each vaccination that you have been vaccinated against. If Yes, please indicate whether there were any reactions and describe in detail)

	No	Yes	Reaction Description
Hepatitis B			
Diphtheria, Tetanus, Pertussis			
Haemophilus Influenza Type B			
Inactivated Polio			
Measles, Mumps, Rubella			
Varicella (Chickenpox)			
Pneumococcal			
Influenza			
Rotavirus			
Human Papilloma Virus (HPV)			

SERIOUS INJURIES AND/OR ACCIDENTS: (Indicate type, date and treatment used)

Type	Date	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

HOSPITALIZATIONS/SURGERIES: (Indicate reason and date)

Reason for Hospitalization	Date
_____	_____
_____	_____
_____	_____

Today's Date:_____

PAST MEDICAL HISTORY-Con't

LABS AND EXAM HISTORY: Please indicate date and results.

Date of last well child check:_____ Results: □ Normal □ Other _____

Date of last blood work:_____ Results: □ Normal □ Other _____

Date of last urine test:_____ Results: □ Normal □ Other _____

Adolescents:

Date of last PAP and pelvic exam:_____ Results: □ Normal □ Other _____

FAMILY HISTORY: Please place a "C" for current or "P" for past in the box next to each condition as it applies to you or your family members.

	Self	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism									
Allergies									
Anemia									
Arthritis									
Asthma									
Cancer									
Depression									
Diabetes									
Drug Addiction									
Eczema									
Epilepsy									
Headaches									
Heart Disease									
Hepatitis									
High Blood Pressure									
Kidney Disease									
Mental Illness									
Stroke									
Tuberculosis									

SOCIAL HISTORY-Con't

BIRTH CONTROL:

Adolescents:

What form of contraception/birth control are you using (Check all that apply).

□ Abstinence □ Withdrawal □ Fertility Awareness Method □ The Sponge □ Spermicide □ Condom □ Diaphragm □ Cervical Cap □ IUD □ The Pill □ The Shot (Depo-Provera) □ The Ring □ Implants □ The Patch □ Vasectomy □ None

TRAVEL HISTORY: Identify any domestic or foreign travel and indicate year of travel:

Place:_____ Year:_____ Place:_____Year:_____

PERSONAL HABITS: Identify any substances you have used and circle whether in the past (P) or are currently using (C)

Adolescents:

Which of the following substances do you use and identify frequency (Ex. 2x/d, 1x/mo, 1x/yr)?

□ Tobacco: P C Freq:_____ □Recreational Drugs: P C Identify type/Freq:_____

□ Alcohol: P C Freq:_____ □Other: P C Specify/Freq:_____

□ Coffee: P C Freq:_____

EXERCISE:

Toddlers/Adolescents:

Do you exercise regularly? □ Yes □ No

If you checked yes to exercising regularly, answer the following questions: What type/activity?_____

How long?_____ How Often?_____

SLEEP:

How many hours of sleep do you get at night on average?_____

Toddlers/Adolescents:

How often do you wake and for what reasons?_____

Do you have any trouble falling asleep? □ No □ Yes/Why?_____

Do you have trouble waking up? □ No □ Yes/Why_____

Do you wake rested? □ Yes □ No/Why _____

ENERGY AND STRESS:

Adolescents:

How would you rate your energy on a scale of 1 – 10 with 10 being the most energy?_____

How would you rate your stress on a scale of 1 – 10 with 10 being the most stress?_____

How do you cope with stress?_____

NUTRITIONAL HISTORY

Infant/Toddlers:

Type: □Nursing □Formula/Specify_____ □Both

Frequency: □Every hour □Every other hour □Every 3rd hour □Every 4th hour □Every 5th hour □Other_____

Duration: □<15 min □15-30 min □30-45 min □45-60 min

Amount per feeding: □<1oz □1-2oz □2-3oz □3-4oz □>4oz

Adolescents:

What is a typical breakfast?_____

What is a typical lunch?_____

What is a typical dinner?_____

What are typical snacks?_____

How many glasses of water do you drink each day on average?_____

Do you have any special dietary restrictions?_____

TRAUMA HISTORY

Prior to your 18th birthday:

Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

No___If Yes, enter 1 __

Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

No___If Yes, enter 1 __

Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

No___If Yes, enter 1 __

Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

No___If Yes, enter 1 __

Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

No___If Yes, enter 1 __

Were your parents ever separated or divorced?

No___If Yes, enter 1 __

Was your mother or stepmother:

Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

No___If Yes, enter 1 __

Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

No___If Yes, enter 1 __

Was a household member depressed or mentally ill, or did a household member attempt suicide?

No___If Yes, enter 1 __

Did a household member go to prison?

No___If Yes, enter 1 __