*NAME*____*SEX*__________*BIRTHDATE*_____________
(*Last name)* *(First)* *(Middle)*

PLEASE ANSWER THE FOLLOWING:

What concerns would you like to have addressed at this visit?

When were these concerns or problems first noted?

Was a specific diagnosis made? If so, what was it, when was it made, and who made it?

What information have you been given (or found on your own) about the child's problems?

What questions do you want to get answers for at this time?

Describe behavior/emotional characteristics or concerns:

Describe type of school program or class or special therapies this child receives:

If possible, list the child's age for developmental milestones listed:

*Head control*_________________________________

*Pulling to stand*______________________________

*Sitting unsupported*__________________________

*Said first words*_______________________________

*Toilet trained*______________________________

*Rolling over*______________________________

*Crawling*_________________________________

*Walking alone*_____________________________

*Used words together*_______________________

IF MEDICAL RECORDS ARE NOT AVAILABLE, PLEASE SUPPLY THE FOLLOWING INFORMATION ABOUT THIS CHILD:

*Birth weight*______________________*Birth length*_____________________

*APGAR Scores (if known)*____

*Head circumference (if known)*___________________________________

Were there any complications or problems at the time of birth or shortly after? If yes, please list problem and treatment if any.

List any unusual or significant physical features and birthmarks.

Complete the following, including ages and dates where known:

SURGERIES OR HOSPITALIZATIONS

ILLNESSES, CHRONIC INFECTIONS AND OTHER HEALTH PROBLEMS

SPECIFIC MEDICAL TESITNG (include hearing and vision tests)

SPECIAL TREATMENT, THERAPY, PRESCRIPTIONS

Name of person completing this form____

Current date____