

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?

Are there changes in your family situation, health of other family members, personal, insurance, or other issues you wish us to know about?

Has your child had any developmental/therapy/school EVALUATIONS OR TESTING since the last visit? _____. If yes, please list, evaluations, who did them, and briefly summarize results:

Describe behavior/emotional characteristics or concerns:

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

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

Current weight_____ Current height_____

Has your child had any medical problems or treatment since last visit?_____. If yes, please complete the following, including ages and dates where known:

SURGERIES OR HOSPITALIZATIONS

ILLNESSES, CHRONIC INFECTIONS AND OTHER HEALTH PROBLEMS

SPECIFIC MEDICAL TESTING (include hearing and vision tests)

SPECIAL TREATMENT, THERAPY, PRESCRIPTIONS

Name of person completing this form_____

Current date_____