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3905 Ford Road, Suite 6

Philadelphia, PA 19131-2824

*Developmental, Medical, Family Information Form*

**Date Form Completed: \_\_\_/\_\_\_/\_\_ Person completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Mo Day Yr Name and relationship to child

**Child’s Name**: **Birth Date: \_\_\_/\_\_\_/\_\_\_Age**:\_\_\_\_\_\_ Sex: **M / F** Mo Day Yr

**Address**:

 Street City State Zip

**Phone:** Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work:\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_ **E-mail**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***CURRENT CONCERNS AND/OR REASONS FOR REFERRAL***

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child has received the diagnosis of an autism spectrum disorder? [ ]  **Yes** [ ]  **No**

If yes, in what month & year \_\_\_\_\_\_\_\_\_ and by whom \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PRENATAL/BIRTH HISTORY***

Parental ages when child was born: Mom \_\_\_\_\_ Dad \_\_\_\_\_

Was this pregnancy full term? [ ]  **Yes** [ ]  **No** If not, how many weeks before or after the expected due date was the baby born? \_\_\_\_\_ weeks [ ]  **BEFORE** [ ]  **AFTER** due date

Pregnancy number: 1st, 2nd, 3rd, 4th, other \_\_\_\_ Totals: # of pregnancies \_\_\_\_\_\_ # of miscarriages \_\_\_\_\_\_

Was this a multiple birth? [ ]  **Yes** [ ]  **No** [ ]  **UK** (unknown); if yes:[ ]  **Twins** [ ] **Triplets** [ ] **Quadruplets**

Were the babies identical?[ ]  **Yes** [ ]  **No** [ ]  **UK** (unknown)

Please describe any problems that occurred during previous pregnancies (e.g., miscarriage, premature labor and delivery, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mother’s health during pregnancy:**

[ ]  No health problems during pregnancy [ ]  Health during pregnancy not known

[ ]  Poor weight gain [ ]  Severe nausea {[ ]  with dehydration}

[ ]  Seizures [ ]  Infections (Flu, measles, CMV)

[ ]  High blood pressure [ ]  Eclampsia/Toxemia

[ ]  Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Rh (blood group) incompatibility

List medications taken during this pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Did the mother consume more than 2 glasses of alcohol a day during this pregnancy? [ ]  Yes [ ]  No

**Labor and Delivery**:

**[ ]** No problems during labor and delivery [ ]  Not known

Please note whether any problems occurred during labor or delivery ( all that apply):

**[ ]** Excessive bleeding **[ ]**  Placenta (bag of water) broke more than 1 day before delivery

**[ ]** Meconium staining [ ]  Umbilical cord around baby’s neck

**[ ]** Fever or infection of mother [ ]  Breathing difficulties of child

**[ ]** Placenta previa or abruption [ ]  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Baby was born  [ ]  head first  [ ]  breech (feet first) [ ]  vaginal  [ ]  Cesarean (Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth weight lbs oz Length in. (if known) Head circumference \_\_\_\_\_\_ in. (if known) Apgar Scores (if known): \_\_\_\_\_\_ at 1 min \_\_\_\_\_\_ at 5 min

**Newborn period:**

Was the child healthy as a newborn? **[ ]  Yes [ ]  No** If not, please describe the problems and treatment:

Was the child born with any birth defects? [ ]  Yes [ ]  No If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the child require treatment in a newborn intensive care unit? [ ]  Yes (for \_\_\_\_\_\_\_\_\_ days) [ ]  No

Did the baby require any special care immediately after birth? [ ]  Yes [ ]  No

If yes, √all that apply

[ ]  Breathing problems (requiring [ ]  oxygen [ ]  ventilator (with a tube in windpipe)

[ ]  Placement in an incubator

[ ]  Blood transfusions

[ ]  Significant muscle weakness or paralysis

[ ]  Poor muscle tone

[ ] Seizures

[ ]  Feeding difficulties

[ ]  Excessive sensitivity to noise/stimulation

**[ ]** Jaundice treated with lights

[ ]  Infection

**[ ]** Surgery (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Developmental History**

[ ]  Developmental milestones not known

*It may be helpful to review infant/toddler milestone books or past reports when completing the following questions. If you are uncertain, estimate as best as you can. Please record the ages in months.*

**N.D. = not yet developed** (not yet walking, not yet speaking in 3-word phrases, etc.)

Smiled in response to others \_\_\_\_\_\_\_ months [ ]  N.D. Bladder control (days) \_\_\_\_\_\_\_ months [ ]  N.D.

Rolled over \_\_\_\_\_\_\_ months [ ]  N.D Bladder control (nights) \_\_\_\_\_\_\_ months [ ]  N.D.

Sat without support \_\_\_\_\_\_\_ months [ ]  N.D. Bowel control \_\_\_\_\_\_\_ months [ ]  N.D.

Crawled \_\_\_\_\_\_\_ months [ ]  N.D.

Stood alone \_\_\_ months [ ]  N.D.

Walked independently \_\_\_\_\_\_\_ months [ ]  N.D.

First words (more than mama, dada) \_\_\_\_\_\_\_ months [ ]  N.D.

Spoke in 3-word phrases \_\_\_\_\_\_\_ months [ ]  N.D.

Spoke in full sentences (at least 4 words) \_\_\_ months [ ]  N.D.

At what age did you **first** notice problems (developmental delays or differences) in:

 Social development \_\_\_\_\_\_\_\_\_\_\_ months

 Speech and language \_\_\_\_\_\_\_\_\_\_\_ months

 Problem solving \_\_\_\_\_\_\_\_\_\_\_ months

 Behavior \_\_\_\_\_\_\_\_\_\_\_ months

**Significant LOSS of an acquired skill or skills (not just a delay)?** For example, a child who was engaging in pretend play with other children for at least 4 to 6 months and then stopped and began just spinning, dropping, or throwing objects in his/her free time or speaking in full sentences for many months and then just stopped speaking altogether or began using only single words occasionally)

Social functioning [ ]  Age of loss: \_\_\_\_\_\_ months; Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Speech / language [ ]  Age of loss: \_\_\_\_\_\_ months; Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Problem solving [ ]  Age of loss: \_\_\_\_\_\_ months; Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Motor coordination [ ]  Age of loss: \_\_\_\_\_\_ months; Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bladder/bowel control [ ]  Age of loss: \_\_\_\_\_\_ months; Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

[ ]  No serious illnesses or injuries in the **past** [ ]  No serious illnesses or injuries **now**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | Age | **Diagnosis/Illness** | **Past** | **Now** | **Date** | Age | **Diagnosis/Illness** | **Past** | **Now** |
|  |  | **Serious Injuries** | **[ ]**  | **[ ]**  |  |  | **Lung/breathing Problems-any** | **[ ]**  | **[ ]**  |
|  |  | Serious head injury | **[ ]**  | **[ ]**  |  |  | Asthma | **[ ]**  | **[ ]**  |
|  |  | Other serious injury | **[ ]**  | **[ ]**  |  |  | Pneumonia | **[ ]**  | **[ ]**  |
|  |  | Loss of consciousness | **[ ]**  | **[ ]**  |  |  | Apnea or irregular breathing | **[ ]**  | **[ ]**  |
|  |  | **Sleep Problems (any)** | **[ ]**  | **[ ]**  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]**  | **[ ]**  |
|  |  | **Neurological Problems** | **[ ]**  | **[ ]**  |  |  | **Stomach/bowel Problems (any)** | **[ ]**  | **[ ]**  |
|  |  | Birth abnormality | **[ ]**  | **[ ]**  |  |  | Swallowing problems | **[ ]**  | **[ ]**  |
|  |  | Seizures (any type)  | **[ ]**  | **[ ]**  |  |  | Gastroesphageal reflux | **[ ]**  | **[ ]**  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | Chronic abdominal pain | **[ ]**  | **[ ]**  |
|  |  | **Vision Problem (any)** | **[ ]**  | **[ ]**  |  |  | Chronic diarrhea | **[ ]**  | **[ ]**  |
|  |  | Vision problems at birth | **[ ]**  | **[ ]**  |  |  | Chronic constipation | **[ ]**  | **[ ]**  |
|  |  | Requires glasses/contacts | **[ ]**  | **[ ]**  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]**  | **[ ]**  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]**  | **[ ]**  |  |  | **Kidney/Bladder Pblm -any** | **[ ]**  | **[ ]**  |
|  |  | **Hearing** **Problem (any)** | **[ ]**  | **[ ]**  |  |  | Abnormalities at birth | **[ ]**  | **[ ]**  |
|  |  | Hearing problems at birth | **[ ]**  | **[ ]**  |  |  | Kidney/bladder infections | **[ ]**  | **[ ]**  |
|  |  | Deafness | **[ ]**  | **[ ]**  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]**  | **[ ]**  |
|  |  | Chronic ear infections | **[ ]**  | **[ ]**  |  |  | **Muscle/bone/joint) Pblms-any** |  |  |
|  |  | Ear tubes | **[ ]**  | **[ ]**  |  |  | Abnormalities at birth | **[ ]**  | **[ ]**  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]**  | **[ ]**  |  |  | Scoliosis or spinal curvature | **[ ]**  | **[ ]**  |
| **Date** | Age | **Diagnosis/Illness** | **Past** | **Now** | **Date** | Age | **Diagnosis/Illness** | **Past** | **Now** |
|  |  | **Dental Problem (any)** | **[ ]**  | **[ ]**  |  |  | **Circulatory Problem (any)** | **[ ]**  | **[ ]**  |
|  |  | Abnormally shaped/ missing teeth | **[ ]**  | **[ ]**  |  |  | Anemia | **[ ]**  | **[ ]**  |
|  |  | Extractions/cavities | **[ ]**  | **[ ]**  |  |  | Sickle cell disease | **[ ]**  | **[ ]**  |
|  |  | Dental braces | **[ ]**  | **[ ]**  |  |  | Chronic low platelet count | **[ ]**  | **[ ]**  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]**  | **[ ]**  |  |  | Bleeding /bruising problem | **[ ]**  | **[ ]**  |
|  |  | **Skin Problem (any)** | **[ ]**  | **[ ]**  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]**  | **[ ]**  |
|  |  | Eczema | **[ ]**  | **[ ]**  |  |  | **Hormone Problem (any)** | **[ ]**  | **[ ]**  |
|  |  | Ash leaf patches | **[ ]**  | **[ ]**  |  |  | Sugar diabetes | **[ ]**  | **[ ]**  |
|  |  | Café-au-lait spots | **[ ]**  | **[ ]**  |  |  | Early puberty | **[ ]**  | **[ ]**  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]**  | **[ ]**  |  |  | Late or incomplete puberty | **[ ]**  | **[ ]**  |
|  |  | **Growth Problem (any)** | **[ ]**  | **[ ]**  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]**  | **[ ]**  |
|  |  | Failure to gain weight | **[ ]**  | **[ ]**  |  |  | **Mental Health problem (any)** | **[ ]**  | **[ ]**  |
|  |  | Obesity | **[ ]**  | **[ ]**  |  |  | ADHD | **[ ]**  | **[ ]**  |
|  |  | Short stature | **[ ]**  | **[ ]**  |  |  | Oppositional defiant disorder | **[ ]**  | **[ ]**  |
|  |  | Tall stature | **[ ]**  | **[ ]**  |  |  | Anxiety disorder | **[ ]**  | **[ ]**  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]**  | **[ ]**  |  |  | Obsessive-compulsive disorder | **[ ]**  | **[ ]**  |
|  |  | **Heart Problem (any)** | **[ ]**  | **[ ]**  |  |  | Depression | **[ ]**  | **[ ]**  |
|  |  | Heart abnormalities at birth | **[ ]**  | **[ ]**  |  |  | Bipolar disorder (manic-depressive) | **[ ]**  | **[ ]**  |
|  |  | Heart surgery | **[ ]**  | **[ ]**  |  |  | Schizophrenia | **[ ]**  | **[ ]**  |
|  |  | Heart rhythm abnormalities | **[ ]**  | **[ ]**  |  |  | Tic disorder (e.g., Tourette) | **[ ]**  | **[ ]**  |
|  |  | High blood pressure | **[ ]**  | **[ ]**  |  |  | Intellectual disability | **[ ]**  | **[ ]**  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]**  | **[ ]**  |  |  | Eating disorder (e.g., anorexia) | **[ ]**  | **[ ]**  |
|  |  |  |  |  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **[ ]**  | **[ ]**  |

I have confirmed with my child’s Primary Care MD that his/her immunizations are up to date. **[ ]**  **Yes [ ]**  **No** **If no, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Specialized neurological or genetic tests:**

[ ]  No neurological or genetic testing has been done

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ** If done** | **Date (if known)****Month/Year** | **Test** | **Normal****Result** | **Abnormal****Result** | **Unknown****Result** |
|  [ ]   |  /  | EEG (brain wave test) |  [ ]  |  [ ]  |  [ ]   |
|  [ ]  |  /  | CT scan | [ ]  |  [ ]  | [ ]  |
|  [ ]  |  /  | MRI scan | [ ]  |  [ ]  | [ ]  |
|  [ ]  |  /  | PET/SPECT/ scanroscopy | [ ]  |  [ ]  | [ ]  |
|  [ ]  |  /  | Other scan (specify): | [ ]  |  [ ]  | [ ]  |
|  [ ]  |  /  | Chromosomal microarray | [ ]  |  [ ]  | [ ]   |
|  [ ]  |  /  | Chromosomal analysis (karyotype) |  [ ]  |  [ ]  | [ ]   |
|  [ ]  |  /  | DNA testing for fragile X syndrome |  [ ]  |  [ ]  |  [ ]  |
|  [ ]  |  /  | Other genetic test:  |  [ ]  |  [ ]  | [ ]   |

**List all hospitalizations and surgeries for the child, include overnight stays (medical or behavioral)**

**[ ]**  No past hospitalizations or surgery

|  |  |  |
| --- | --- | --- |
| **Reason for hospitalization/surgery** | **Age**  | **Length of stay** |
|  |  |  |
|  |  |  |
|  |  |  |

**Allergies** (to medications, foods, environmental antigens, etc.)

[ ]  No past or current allergies

|  |  |
| --- | --- |
| **Source (medication, food, etc.)** | **Nature of reaction (hives, trouble breathing, etc.)** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Current Medications**

[ ]  No medications taken **now** [ ]  Medications are being taken now, but the names are not known

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dosage** | **Age at start** | **Reason for medication** | **Improved** |
|  |  |  |  | [ ] **Y** | [ ] **N** |
|  |  |  |  | [ ] **Y** | [ ] **N** |
|  |  |  |  | [ ] **Y** | [ ] **N** |
|  |  |  |  | [ ] **Y** | [ ] **N** |
|  |  |  |  | [ ] **Y** | [ ] **N** |
|  |  |  |  | [ ] **Y** | [ ] **N** |

**Name of person prescribing the medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Past Medications**

**[ ]** No medications taken in the **past** **[ ]** Medications were taken in the past, but the names are not known

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Dates (month/year)** | **Reasons for prescription** | **Response to medication** **(positive & negative)** |
|  |  / to /  |  |  |
|  |  / to /  |  |  |
|  |  / to /  |  |  |
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|  |  / to /  |  |  |

**FAMILY/SOCIAL HISORY:**

Please list all the people who live with child. Please include name, age, and relationship to child)

**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BROTHERS AND SISTERS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name of sibling** | **Sex** | **Age** | **Different****Father?** | **Different****Mother?** | **List any health/behavior/ learning problems** | **Lives with child?** |
|  |  |  | [ ] **Y** [ ] **N** | [ ] **Y** [ ] **N** |  | [ ] **Y** [ ] **N** |
|  |  |  | [ ] **Y** [ ] **N** | [ ] **Y** [ ] **N** |  | [ ] **Y** [ ] **N** |
|  |  |  | [ ] **Y** [ ] **N** | [ ] **Y** [ ] **N** |  | [ ] **Y** [ ] **N** |
|  |  |  | [ ] **Y** [ ] **N** | [ ] **Y** [ ] **N** |  | [ ] **Y** [ ] **N** |
|  |  |  | [ ] **Y** [ ] **N** | [ ] **Y** [ ] **N** |  | [ ] **Y** [ ] **N** |

**FAMILY MEDICAL HISTORY (**Include only **biological** relatives **diagnosed** **by a doctor.** For brothers and sisters record the **number** that have received the diagnosis. For other relatives, please check the box)

**Mother, Father** = the biological parents of the child or adolescent being referred for this evaluation

**Brothers, Sisters** = siblings of the referred child/adolescent with the same biological mother **and/or** father

**Grandmother (GM), Grandfather (GF)** = the biological parents of the referred child’s biological parents

**Aunts, Uncles** = biological sisters and brothers of the referred child’s biological mother or father

**Cousins** = biological children of the referred child’s biological aunts or uncles

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Condition/Disorder** | **Mother** **(**√**)** | **Father** **(√)** | **Number of Brothers** | **Number of sisters** | **GM****(√)** | **GF****(√)** | **Aunts****(√)** | **Uncles****(√)** | **cousins****(√)** |
| Autistic Disorder |  |  |  |  |  |  |  |  |  |
| Autism spectrum disorder or Pervasive developmental dis. |  |  |  |  |  |  |  |  |  |
| Asperger syndrome |  |  |  |  |  |  |  |  |  |
| Fragile X syndrome |  |  |  |  |  |  |  |  |  |
| Tuberous sclerosis |  |  |  |  |  |  |  |  |  |
| Other genetic disorders |  |  |  |  |  |  |  |  |  |
| Intellectual disability |  |  |  |  |  |  |  |  |  |
| Learning disability |  |  |  |  |  |  |  |  |  |
| Language disorder |  |  |  |  |  |  |  |  |  |
| Attention deficit disorder |  |  |  |  |  |  |  |  |  |
| Tourette’s syndrome |  |  |  |  |  |  |  |  |  |
| Seizure disorder (epilepsy) |  |  |  |  |  |  |  |  |  |
| Obsessive compulsive dis |  |  |  |  |  |  |  |  |  |
| Other anxiety disorders |  |  |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |  |  |
| Bipolar disorder |  |  |  |  |  |  |  |  |  |
| Schizophrenia |  |  |  |  |  |  |  |  |  |
| Alcoholism |  |  |  |  |  |  |  |  |  |
| Drug addiction |  |  |  |  |  |  |  |  |  |
| Birth defects (e.g. cleft lip, club foot, heart defect) |  |  |  |  |  |  |  |  |  |
| Gland/endocrine ex thyroid, diabetes, delayed puberty |  |  |  |  |  |  |  |  |  |
| Immune disorders (e.g. arthritis, lupus) |  |  |  |  |  |  |  |  |  |

**RESOURCES**: Please **** resources/services being received **now**

**[ ]**  No resources/services are being received now

[ ]  Early Intervention Services (Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

[ ]  Speech/Language therapy [ ]  Psychiatry services [ ]  Behavioral therapy [ ]  Group therapy [ ]  Physical therapy

[ ]  Occupational therapy [ ]  Case management [ ]  Wraparound services (WRAP) [ ]  Mobile Therapist (MT)

[ ]  Behavior Specialist Consultant (BSC) [ ]  Therapeutic Staff Support (TSS) [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EDUCATIONAL HISTORY**

School name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:

Grade in school: (ever repeat a grade? Yes / No)Teacher (or best contact): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ IEP □ 504 Plan □ Special Ed □ Services: OT/PT/SLT

What best describes your child’s current educational program?

Full time in a regular class [ ]

Time split between regular and special education classes [ ]

Special education class [ ]

Aide/Paraprofessional or extra help [ ]

Specialized school [ ]

Home schooled [ ]

**Please indicate the educational program in which your child participated during his/her school\* years:**

|  |  |  |  |
| --- | --- | --- | --- |
| **School Year** |  **Type of School**Regular**\*** Special |  **Type of Class**Regular\*Special\* |  Any Special ServicesYes No Type |
| 3-5 preschool |  |  |  |  |  |  |  |
| Kindergarten |  |  |  |  |  |  |  |
| 1st |  |  |  |  |  |  |  |
| 2nd  |  |  |  |  |  |  |  |
| 3rd |  |  |  |  |  |  |  |
| 4th |  |  |  |  |  |  |  |
| 5th |  |  |  |  |  |  |  |
| 6th |  |  |  |  |  |  |  |
| 7th |  |  |  |  |  |  |  |
| 8th |  |  |  |  |  |  |  |
| 9th |  |  |  |  |  |  |  |
| 10th |  |  |  |  |  |  |  |
| 11th |  |  |  |  |  |  |  |
| 12th  |  |  |  |  |  |  |  |

**\* REGULAR school applies to public or private schools for children without disabilities.**

 **SPECIAL school applies to any schools intended for children with disabilities**