****

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. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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

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

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

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

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

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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/ scan  roscopy |  |  |  |
|  | / | 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 / |  |  |
|  | / to / |  |  |
|  | / to / |  |  |
|  | / to / |  |  |
|  | / to / |  |  |
|  | / to / |  |  |
|  | / to / |  |  |
|  | / 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 Services  Yes 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**