



**E. THERAPIES** (received/receiving) which are not related to early intervention or special education services:

Occupational therapy  Physical therapy  Speech therapy Therapy Agency: \_\_\_\_\_

**F. EDUCATIONAL & ACADEMIC INFORMATION**

NAME OF CHILD'S SCHOOL: \_\_\_\_\_ City: \_\_\_\_\_ Current Grade: \_\_\_\_\_

If applicable: # of years retained: \_\_\_\_\_ which grade(s)? \_\_\_\_\_ # years skipped: \_\_\_\_\_ which grade(s): \_\_\_\_\_ Current reading level: \_\_\_\_\_

**G. \*\*\*COMPLETE THE NEXT SECTION ONLY IF YOUR CHILD WAS ENROLLED IN EARLY INTERVENTION OR SPECIAL EDUCATION**

EARLY INTERVENTION (BIRTH TO 3 YEARS OF AGE):

Child received services but was discharged or transitioned/moved to special education program.

Child is currently receiving early intervention services.

Specific therapies that the child received or is currently receiving:  Physical  Occupational  Speech  Other \_\_\_\_\_

SPECIAL EDUCATION SERVICES: (PAST AND/OR PRESENT)

SPECIAL EDUCATION ELIGIBILITY CLASSIFICATION (IEP):

Developmentally Delayed (DD)  Cognitively Impaired (Previously referred to as "Mentally Retarded")

Emotionally Disturbed (ED)  Speech/Language Impaired  Hearing impaired

Autistic  Other health impaired (OHI)  Visually impaired

Specific Learning Disability (SLD) \*\*\*in what subject(s) (i.e. reading, math, written expression)\_\_\_\_\_

CLASSROOM SETTING \*\*\*COMPLETE THIS ONLY IF CHILD IS IN SPECIAL EDUCATION\*\*\*

Preschool program  Full day or contained special classroom  Part day or resource  SECEP

THERAPIES RECEIVED/RECEIVING IN SCHOOL:  Occupational therapy  Physical therapy  Speech therapy  Other

**H. PLEASE LIST ANY UNUSUAL AND/OR TRAUMATIC FAMILY EVENT IN YOUR CHILD'S LIFE WHICH YOU FEEL MAY HAVE AFFECTED**

**YOUR CHILD** (Examples: birth of sibling, death in the family, divorce, illnesses, frequent school changes, abuse)

EVENT	CHILD'S AGE AT TIME OF EVENT	COMMENTS

**I. PEER RELATIONSHIPS & SOCIAL SKILLS**

Are there same age children in your neighborhood?  Yes  No

Does your child seek friendships with same age peers?  Yes  No

Is your child sought by peers for friendship?  Yes  No

Does your child have trouble making or keeping friends?  Yes  No If yes, please explain: \_\_\_\_\_

Who does your child prefer to play with?  Younger children  Older children  Same age children

Family members only  Alone/Solitary  Prefers adults

**J. INTERESTS AND ACCOMPLISHMENTS OF YOUR CHILD**

What are your child's favorite toys, games, hobbies, and interests? \_\_\_\_\_

Clubs, sports, recreational activities: \_\_\_\_\_

What are your child's areas of greatest accomplishment? \_\_\_\_\_

What does your child dislike doing most? \_\_\_\_\_

What do you like most about your child? \_\_\_\_\_

**K. BIRTH/NEWBORN HISTORY**

1. Was the baby born on time (term gestation)?  Yes  No *Number of weeks born: early \_\_\_\_\_ late \_\_\_\_\_*
  - State reason (if known) for preterm or early birth: \_\_\_\_\_
2. Baby’s birth weight: \_\_\_\_\_ Mother’s age at the time of this pregnancy: \_\_\_\_\_
3. List any complications or illnesses which occurred during this pregnancy: \_\_\_\_\_
4. List *prescribed* medications taken during this pregnancy: \_\_\_\_\_
5. List any *over-the-counter* medications taken during *this* pregnancy: \_\_\_\_\_
6. Did the mother drink any alcohol during this pregnancy?  No  Yes  Suspected  Not known
  - Number of drinks per day *and* in which trimesters: \_\_\_\_\_
7. Did the mother smoke cigarettes while pregnant?  No  Yes  Suspected  Not known Packs per day: \_\_\_\_\_
8. Did the mother take any illegal/street drugs used during the pregnancy?  No  Yes  Suspected  Not known
  - Cocaine  Marijuana  Heroin  Other: \_\_\_\_\_
9. Type of delivery:  vaginal  cesarean section (C/S)  forceps  vacuum extraction  breech
10. Reason for delivery if not vaginal or repeat C/S:  fetal distress  premature rupture of membranes  high blood pressure (mother)  Pre-eclampsia  Breech presentation  Other: \_\_\_\_\_
11. Was resuscitation or oxygen required?  Yes  No. Apgar score (if known): \_\_\_\_\_ at 1 minute \_\_\_\_\_ at 5 minutes
12. Did the baby spend time in the special care nursery or NICU following birth?  No  Yes If yes, please explain: \_\_\_\_\_
13. Did your baby pass his/her newborn hearing screen prior to discharge from the hospital?  No  Yes
14. Infant’s age when discharged from nursery? \_\_\_\_\_

**L. CHILD’S TEMPERAMENT DURING FIRST MONTHS OF LIFE:**

Difficult to calm or console? <input type="radio"/> Yes <input type="radio"/> No	Enjoyed being held or cuddled? <input type="radio"/> Yes <input type="radio"/> No
Excessive irritability or fussiness? <input type="radio"/> Yes <input type="radio"/> No	Difficulty developing a predictable routine? <input type="radio"/> Yes <input type="radio"/> No

**M. DEVELOPMENTAL MILESTONES** **\*\*AGE YOUR CHILD WAS CONSISTANTLY DOING THE FOLLOWING:**

**GROSS MOTOR MILESTONES**

Rolled over \_\_\_\_\_ sat unsupported \_\_\_\_\_ crawled \_\_\_\_\_ pulled to stand \_\_\_\_\_ cruised (walk holding on to furniture) \_\_\_\_\_ walked independently \_\_\_\_\_ ran well \_\_\_\_\_ pedaled a tricycle \_\_\_\_\_ rode a 2 wheel bike *with* training wheels \_\_\_\_\_ rode a 2-wheel bike *without* training wheels \_\_\_\_\_

**FINE MOTOR MILESTONES**

Reached and grasped small objects \_\_\_\_\_ transferred object from one hand to another \_\_\_\_\_ finger fed self \_\_\_\_\_ drank from cup (without a cover with minimal spilling) \_\_\_\_\_ fed self with spoon \_\_\_\_\_ undressed \_\_\_\_\_ dressed \_\_\_\_\_ potty trained \_\_\_\_\_ Age child showed definite hand preference \_\_\_\_\_ (My child is:  left handed  right handed)

**LANGUAGE MILESTONES**

Smiled \_\_\_\_\_ cooed (long vowel sounds) \_\_\_\_\_ laughed out loud \_\_\_\_\_ razzed (blowing raspberries) \_\_\_\_\_ babbled (ba-ba, ma-ma) \_\_\_\_\_ said “mama” (specifically for mother) \_\_\_\_\_ said “dada”(specifically for father) \_\_\_\_\_ said first word (other than mama or dada) \_\_\_\_\_ consistently used two-word sentences \_\_\_\_\_ consistently used pronouns correctly (I, me, he she) \_\_\_\_\_ waved “bye bye” \_\_\_\_\_ played “patty cake” \_\_\_\_\_ followed one-step commands \_\_\_\_\_ pointed to pictures in book \_\_\_\_\_ knew 2 or more body parts \_\_\_\_\_ stated full name \_\_\_\_\_ stated age \_\_\_\_\_ stated address \_\_\_\_\_

**SOCIAL MILESTONES: APPROXIMATE AGE YOUR CHILD WOULD CONSISTENTLY:**

Follow *your* gaze or look in the direction in which you are looking \_\_\_\_\_

Follow *your* point or look in the direction in which you pointed \_\_\_\_\_

Point to *request* an object: \_\_\_\_\_

Bring you objects to *show or share* with you (not to request help such as opening a container) \_\_\_\_\_

Point to show you something interesting (and look back to make sure you are doing this) \_\_\_\_\_

Engage in pretend play (ex: feeding a baby doll or making car sounds) \_\_\_\_\_

**N. ANY HISTORY OF LOSS OF DEVELOPMENTAL MILESTONES** (\*\*Skills which the child was consistently doing...not once or twice)

NO  YES IF YES, PLEASE EXPLAIN: \_\_\_\_\_

**O. WHAT IS THE FUNCTIONAL AGE OF YOUR CHILD** (age your child acts the majority of the time) \_\_\_\_\_

IF DIFFERENT THAN CHRONOLOGICAL AGE, PLEASE EXPLAIN: \_\_\_\_\_

**P. WHO LIVES IN THE HOME WITH THE CHILD?** \_\_\_\_\_

**PARENT MARITAL STATUS:**  Single  Married  Separated  Divorced  Never married

Both parents are involved in live of this child or child rarely sees:  Father  Mother

**PARENT INFORMATION** (\*\*Please include information for biological parents)

	FATHER	MOTHER
FULL NAME:		
ADDRESS: (If does not live with child)		
CURRENT AGE:		
OCCUPATION:		
HIGHEST GRADE COMPLETED:		
EARLY SCHOOL LEARNING PROBLEMS?		
BEHAVIOR OR PSYCHIATRIC ISSUES?		
SOCIAL OR LEGAL PROBLEMS?		

**SIBLINGS:** (BROTHERS OR SISTERS) \*USE BACK IF NEEDED

NAME	SEX	AGE	GRADE	SPEECH/LANGUAGE/SCHOOL ISSUES:	FULL OR HALF SIBLING?
1.					<input type="checkbox"/> Full <input type="checkbox"/> Half Share: <input type="checkbox"/> Mother <input type="checkbox"/> Father
2.					<input type="checkbox"/> Full <input type="checkbox"/> Half Share: <input type="checkbox"/> Mother <input type="checkbox"/> Father
3.					<input type="checkbox"/> Full <input type="checkbox"/> Half Share: <input type="checkbox"/> Mother <input type="checkbox"/> Father
4.					<input type="checkbox"/> Full <input type="checkbox"/> Half Share: <input type="checkbox"/> Mother <input type="checkbox"/> Father
5.					<input type="checkbox"/> Full <input type="checkbox"/> Half Share: <input type="checkbox"/> Mother <input type="checkbox"/> Father

**REVIEW OF SYSTEMS (CHILD'S CURRENT & PAST HEALTH HISTORY)**

<b>(1) HOSPITALIZATIONS:</b> <input type="radio"/> None <input type="radio"/> Yes <i>*If yes, please provide date and reason for the hospitalization (s):</i>				
<b>SURGERIES:</b> <input type="radio"/> None <input type="radio"/> Yes <i>*If yes, please list approximate date and type of surgery:</i>				
<b>SERIOUS ACCIDENTS OR INJURIES:</b> <input type="radio"/> None <input type="radio"/> Yes <i>* If yes, please describe:</i>				
<b>CURRENT PERSDRIBED &amp; "OVER THE COUNTER" MEDICATIONS ( HEALTH SUPPLEMTNS OR VITAMINS) &amp; DOSAGE:</b> <input type="radio"/> Child is on no medications				
<b>LIST MEDICATIONS PREVIOUSLY TAKEN:</b>				
<b>***ALLERGIES TO MEDICATIONS OR FOODS:</b> <input type="radio"/> None <input type="radio"/> Yes <i>If yes, please describe:</i>				
<b>***ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE?</b> <input type="radio"/> Yes <input type="radio"/> NO <i>If not, why?</i>				
BODY SYSTEM	PLEASE INDICATE IF CHILD HAS "HISTORY OF" OR CURRENT PROBLEMS WITH:	YES	NO	COMMENTS
<b>(2) HEAD</b>	Head injury: <i>If yes, was there loss of consciousness? O no O yes</i>			
<b>EARS</b>	Recurrent ear infections:			
	Ear surgeries (i.e. PE tubes in ears):			
	Hearing tested <i>other than</i> the newborn screen? <i>**If so, by whom and when?</i>			
<b>EYES</b>	Has the child's vision been tested? <i>**If so, by whom and when?</i>			
	Does your child wear glasses or contacts:			
	History of eye surgeries:			
<b>NOSE/THROAT</b>	Sinus infections:			
	Does your child snore:			
	Surgeries to remove: <input type="radio"/> Tonsils <input type="radio"/> Adenoids			
<b>(3) A. CHILD HISTORY CARDIOVASCULAR</b>	<b>Past or current history for the CHILD of any of the following:</b> <input type="radio"/> High Blood Pressure <input type="radio"/> Heart murmur <input type="radio"/> Rheumatic Fever <input type="radio"/> Fainting Dizziness <input type="radio"/> Abnormal heart structure <input type="radio"/> Unusually fast heart rate <input type="radio"/> Shortness of breath <input type="radio"/> Palpations (extra or skipped heart beats) <input type="radio"/> Chest pain (especially with exertion or exercise) <input type="radio"/> Unexplained or noticeable change in exercise tolerance <input type="radio"/> History of a viral illness with chest pains or palpitations			
	<b>B. FAMILY HISTORY CARDIOVASCULAR</b>  History of any heart or cardiac problems in the child's PARENTS & EXTENDED FAMILY MEMBERS requiring medications, medical care, hospitalization, or surgery?  <i>Please check if any family members have had any of the following conditions:</i> <input type="radio"/> Sudden cardiac death or fainting requiring resuscitation in family member less than 35 years. <input type="radio"/> Sudden unexplained death in someone young or during exercise. <input type="radio"/> Cardiomyopathy (enlarged heart.) <input type="radio"/> Arrhythmias (abnormal heart rhythms or beats). Any Syndromes? <input type="radio"/> Marfan <input type="radio"/> Long or Short QT <input type="radio"/> Brugada <input type="radio"/> Wolff-Parkinson-White			
<b>(4) RESPIRATORY</b>	Asthma:			
	Pneumonia:			
	Exposure to Tuberculosis (TB):			
<b>(5)HEMATOLOG</b>	Anemia or easy bruising:			
<b>(6) GI</b>	History of poor appetite or other problems with eating such as oral aversion:			
	Gastroesophageal reflex (GERD):			
	Bowel issues: <input type="radio"/> Chronic constipation <input type="radio"/> Chronic diarrhea Any significant recent weight change: ( <i>indicate weight gain or loss</i> )			
<b>(7) GU</b>	<input type="radio"/> History of bedwetting <input type="radio"/> current problems with bedwetting			
	History of urinary tract infections: Has your child's menstrual cycle started? (females only)			
<b>(8) SKIN</b>	Eczema:			
	Birth marks: <i>***if yes, please describe birthmark and location</i>			
<b>(9) ENDOCRINE</b>	Thyroid problems:			
	History of abnormal lead level:			
	Diabetes:			
<b>(10) ORTHOPEDIC</b>	Broken bones or fractures:			
<b>(11) NEURO</b>	Seizures or convulsions:			
	Frequent staring spells during which you can't get the child's attention:			
	Headaches:			
	Loss of conscious:			
	Tics:			
	Loss of developmental skill or body functions:			
	<input type="radio"/> MRI ( <i>and/or</i> ) <input type="radio"/> CAT scan of the Brain: <i>Please include result if known:</i>			
	EEG: <i>Please include result if known:</i>			
<b>(12) GENETICS</b>	History of a genetic or inheritable disorder or chromosome testing for other reason:			

**FAMILY DEVELOPMENTAL & PSYCHIATRIC (MENTAL HEALTH) HISTORY**

\*\*\*Please indicate if family members (grandparents, aunts, uncles, brothers, sisters, first cousins) have any of the following:

DISORDER/CONDITION	IF YES, CHECK	WHICH FAMILY MEMBER ** RELATION (PARENT, GRANDPARENT, ETC.)	MOTHER (MATERNAL) OR FATHER'S (PATERNAL) SIDE OF THE FAMILY	COMMENTS
1. Congenital deafness or hearing impairment:			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
2. Blind or visually impaired:			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
3. Autism, Asperger Disorder, or PDD-NOS:			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
4. Reading disability or Dyslexia:			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
5. Other learning disabilities (math, writing, etc.):			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
6. Mentally retarded or cognitive challenged/impaired:			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
7. Genetic or inherited disorders or abnormalities:			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
8. ADHD:			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
9. Aggressiveness:			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
10. Oppositional defiant disorder (ODD):			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
11. Conduct Disorder:			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
12. Alcohol Abuse:			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
13. Substance abuse (marijuana, crack cocaine, LSD):			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
14. Physical abuse or sexual abuse:			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
15. Depression:			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
16. Anxiety Disorder:			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
17. Psychosis (seeing or hearing things that others do not):			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
18. Schizophrenia:			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
19. Bipolar Disorder, Manic Depressive Disorder, Unusual mood swings:			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
20. Tic disorders:			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
21. Antisocial behaviors (assaults, thefts, arrests, jail):			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
22. Oppositional behavior as a child or adult:			<input type="radio"/> Mother's <input type="radio"/> Fathers'	
23. OTHER:				

**PLEASE ADD ANYTHING ELSE YOU WOULD LIKE TO SHARE ABOUT YOUR CHILD:**

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