



# PATIENT HISTORY

Name: \_\_\_\_\_  
 MR #: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 or Apply Patient Label

**Please complete the following:**

Patient's Name: \_\_\_\_\_

Age of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Primary Language:  English  Español  Other \_\_\_\_\_

Is your child:  Right handed  Left handed  Both

|                        | Name | Address | Telephone | Fax |
|------------------------|------|---------|-----------|-----|
| Primary Care Physician |      |         |           |     |
| Referring Physician    |      |         |           |     |

**Other Providers Caring for your child:**

| Specialty | Name | Address | Telephone | Fax |
|-----------|------|---------|-----------|-----|
|           |      |         |           |     |
|           |      |         |           |     |
|           |      |         |           |     |
|           |      |         |           |     |

**What are your main questions or concerns that brought you to our office:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**List current prescription, over the counter, and herbal medications, vitamins, and supplements (include dose and schedule):**

| Medication | Dose | How Often |
|------------|------|-----------|
|            |      |           |
|            |      |           |
|            |      |           |
|            |      |           |

**List allergies and drug reactions:**

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

Are immunizations up to date?  Yes  No





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|                        |       |
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**List past medical problems:**

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**List past surgeries (include dates or age at time of surgery and place of surgery if possible):**

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**List previous medications used to treat the condition you are coming in for today:**

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**List previous diagnostic tests or labs you have had, where they were done and when:**

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## Pregnancy, Labor, and Delivery

**Prenatal screening completed (circle results):**

|               |          |          |            |          |
|---------------|----------|----------|------------|----------|
| Group B Strep | Positive | Negative | Don't Know | Not Done |
| Hepatitis B   | Positive | Negative | Don't Know | Not Done |
| HIV           | Positive | Negative | Don't Know | Not Done |
| Rubella       | Positive | Negative | Don't Know | Not Done |

**Information about Birth Mother (please answer):**

|  |  |  |
|--|--|--|
| Age at delivery?                                   |  |  |
| What number pregnancy was this                     |  |  |
| What number live birth for mother?                 |  |  |
| How many pounds were gained during this pregnancy? |  |  |
| Was conception by invetro fertilization?           |  |  |
| Was genetic testing done?                          |  |  |
| How many prior miscarriages?                       |  |  |
| How many prior abortions?                          |  |  |

**During the pregnancy, did the birth mother have any of the following concerns? (circle response)**

|               |                     |                    |                      |                |
|---------------|---------------------|--------------------|----------------------|----------------|
| Anemia        | Bleeding            | Fever              | Infection            | Multiple fetus |
| Preterm labor | High blood pressure | Exposure to X-rays | Gestational Diabetes |                |

**During pregnancy, did the birth mother use (please list):**

|              |  |
|--------------|--|
| Medications  |  |
| Cigarettes   |  |
| Alcohol      |  |
| Street Drugs |  |

**Child birth:**

|                                  |                                    |                       |  |
|----------------------------------|------------------------------------|-----------------------|--|
| Hospital of birth                |                                    | Length of labor       |  |
| Gestational age?                 |                                    | Presentation          | <input type="checkbox"/> Head <input type="checkbox"/> Breech <input type="checkbox"/> Arm |
| Birth weight                     |                                    | Difficult delivery?   | <input type="checkbox"/> Yes <input type="checkbox"/> No                                   |
| Birth length                     |                                    | Vacuum / forceps      | <input type="checkbox"/> Yes <input type="checkbox"/> No                                   |
| Head size                        |                                    | Arm or shoulder stuck | <input type="checkbox"/> Yes <input type="checkbox"/> No                                   |
| <input type="checkbox"/> Vaginal | <input type="checkbox"/> C-section |                       |  |
| If C-section, why?               |                                    |                       |  |

**After delivery, did the child experience any of the following? (Please circle)**

|                   |                     |                   |                  |
|-------------------|---------------------|-------------------|------------------|
| Resuscitation     | ICU care            | Bleeding in Brain | Infection        |
| Ventilator        | Jaundice            | Hydrocephalus     | Eye problems     |
| Oxygen            | Feeding problems    | Seizures          | Hearing problems |
| CPAP              | Apnea / Bradycardia | Blood transfusion | Birth defects    |
| Arm/limb weakness |                     |                   |                  |

Did the child require x-rays? \_\_\_\_\_

How old was child when discharged from the hospital? \_\_\_\_\_

To whom was child discharged? \_\_\_\_\_

Did the Birth Mother have post-partum depression (feel sad after delivery)?     Yes     No





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### Developmental History

Do you think your child developed normally?  Yes  No  
 Do you think your child can see well?  Yes  No Formally tested?  Yes  No  
 Do you think your child can hear well?  Yes  No Formally tested?  Yes  No  
 At what age did your child meet these milestones? Indicate age in months.

| MOTOR           |  | SELF-HELP           |  | LANGUAGE        |  |
|-----------------|--|---------------------|--|-----------------|--|
| Sit up          |  | Hold bottle         |  | Babble          |  |
| Crawl           |  | Give up bottle      |  | Mama / Dada     |  |
| Walk alone      |  | Use Spoon           |  | Another word    |  |
| Run             |  | Use Fork            |  | Understand "no" |  |
| Pedal trike     |  | Drink from open cup |  | Point           |  |
| Bicycle         |  | Undress             |  | Wave            |  |
| Stairs          |  | Toilet-trained      |  | Follow command  |  |
| Pincer grasp    |  | Dry at night        |  | 2-word phrases  |  |
| Prefer one hand |  | Dress self          |  | 3-word phrases  |  |

### Does your child require or have special equipment of daily living?

- Braces \_\_\_\_\_
- Walker or crutches \_\_\_\_\_
- Wheelchair \_\_\_\_\_
- Communication devices \_\_\_\_\_
- Other \_\_\_\_\_

### THERAPY HISTORY

Did your child receive early intervention?  Yes  No  
 If yes, please describe:

|                      | From Whom? | How often? |
|----------------------|------------|------------|
| Speech               |            |            |
| Occupational Therapy |            |            |
| Physical Therapy     |            |            |

### SCHOOL HISTORY

| SCHOOLS & PRESCHOOLS ATTENDED | DATES ENROLLED | SPECIAL EDUCATION | THERAPIES |
|-------------------------------|----------------|-------------------|-----------|
|                               |                |                   |           |
|                               |                |                   |           |
|                               |                |                   |           |
|                               |                |                   |           |
|                               |                |                   |           |

Performance in School      Excellent    Good      Average    Poor  
 Reading level- if known:      Excellent    Good      Average    Poor  
 Math level- if known:      Excellent    Good      Average    Poor  
 Behavior- Does your child have any of the following:      At home?      At school?  
 Hyperactivity              
 Short attention span              
 Impulsivity              
 Poor judgment              
 Moodiness              
 Distractibility              
 Has your child had developmental or neuropsychological testing?       Yes (please explain)       No  
 Where? \_\_\_\_\_





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Results: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Family History

- No known family health problems       Unknown, patient is adopted

Do parents, siblings, grandparents, aunts, uncles, or cousins have any of the following? If so, who?

|                          | Condition                    | Which family member? |
|--------------------------|------------------------------|----------------------|
| <input type="checkbox"/> | Asthma                       |                      |
| <input type="checkbox"/> | Bleeding / Clotting disorder |                      |
| <input type="checkbox"/> | Diabetes                     |                      |
| <input type="checkbox"/> | Heart Disease                |                      |
| <input type="checkbox"/> | Hypertension                 |                      |
| <input type="checkbox"/> | Early or sudden death        |                      |
| <input type="checkbox"/> | Liver Disease                |                      |
| <input type="checkbox"/> | Cancer                       |                      |
| <input type="checkbox"/> | Thyroid                      |                      |
| <input type="checkbox"/> | Neurofibromatosis            |                      |
| <input type="checkbox"/> | Tuberous Sclerosis           |                      |
| <input type="checkbox"/> | Genetic / Metabolic Disorder |                      |
| <input type="checkbox"/> | Brain or spinal tumor        |                      |
| <input type="checkbox"/> | Craniosynostosis             |                      |
| <input type="checkbox"/> | Headaches / Migraines        |                      |
| <input type="checkbox"/> | Seizures/Epilepsy            |                      |
| <input type="checkbox"/> | Nerve or Muscle disease      |                      |
| <input type="checkbox"/> | Birth defects                |                      |
| <input type="checkbox"/> | Blind / Deaf                 |                      |
| <input type="checkbox"/> | Cerebral Palsy               |                      |
| <input type="checkbox"/> | Spina Bifida                 |                      |
| <input type="checkbox"/> | Down Syndrome                |                      |
| <input type="checkbox"/> | Movement Disorders           |                      |
| <input type="checkbox"/> | Tics / Tourette syndrome     |                      |
| <input type="checkbox"/> | Intellectual Delay           |                      |
| <input type="checkbox"/> | Developmental Delays         |                      |
| <input type="checkbox"/> | Learning Disabilities        |                      |
| <input type="checkbox"/> | ADHD / attention problems    |                      |
| <input type="checkbox"/> | Hyperactivity                |                      |
| <input type="checkbox"/> | Drug abuse                   |                      |
| <input type="checkbox"/> | Alcoholism                   |                      |







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### General Review of Systems

Does the patient have any of the following problems or complaints? Please check.

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <b>Yes</b>               | <b>No</b>                | <b>General</b>                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent fevers, chills, or sweats                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Significant weight loss or weight gain            |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in behavior                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Tiredness or drowsiness                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Lack of interest in play                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of appetite                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems related to sleep                         |
| <b>Yes</b>               | <b>No</b>                | <b>Skin</b>                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Rashes or sores                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth marks                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Other problems:                                   |
| <b>Yes</b>               | <b>No</b>                | <b>Endocrine</b>                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive sweating                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive thirst and urination                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive hunger                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Always too cold or too hot                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Premature sexual development/ early onset puberty |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Other problems:                                   |
| <b>Yes</b>               | <b>No</b>                | <b>Eyes</b>                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased vision or blurred vision                |
| <input type="checkbox"/> | <input type="checkbox"/> | Double vision                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Lazy eye or eyes not working together             |
| <input type="checkbox"/> | <input type="checkbox"/> | Wears glasses or contacts                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Other problems:                                   |
| <b>Yes</b>               | <b>No</b>                | <b>Ears, Nose, Throat</b>                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Ringing in ears                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear infections or drainage from ears              |
| <input type="checkbox"/> | <input type="checkbox"/> | Nasal discharge or congestion                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing liquids or solids           |
| <input type="checkbox"/> | <input type="checkbox"/> | Drooling  |

- |                          |                          |                                   |
|--------------------------|--------------------------|-----------------------------------|
| <b>Yes</b>               | <b>No</b>                | <b>Gastrointestinal</b>           |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea and / or vomiting          |
| <input type="checkbox"/> | <input type="checkbox"/> | Tummy pain or discomfort          |
| <input type="checkbox"/> | <input type="checkbox"/> | Feeding problems                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Gastro-esophageal reflux          |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation or diarrhea control  |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss or change in bowel control   |
| <input type="checkbox"/> | <input type="checkbox"/> | Other problems                    |
| <b>Yes</b>               | <b>No</b>                | <b>Urinary</b>                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent or excessive urination   |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain on urination                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary tract infections          |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss or change in bladder control |
| <input type="checkbox"/> | <input type="checkbox"/> | Bedwetting                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Other problems:                   |
| <b>Yes</b>               | <b>No</b>                | <b>Muscles and Bones</b>          |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint pain or joint swelling      |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle spasms or cramps           |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness, excessive falling       |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive tightness of muscles    |
| <input type="checkbox"/> | <input type="checkbox"/> | Spasticity                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal postures                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Uncontrollable movements          |
| <input type="checkbox"/> | <input type="checkbox"/> | Tremors or tics                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Scoliosis / curvature of spine    |
| <input type="checkbox"/> | <input type="checkbox"/> | Broken bones                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Other problems:                   |
| <b>Yes</b>               | <b>No</b>                | <b>Hematological</b>              |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent or easy bruising         |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble controlling bleeding      |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Other problems:                   |





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- Regurgitation through the nose
- Frequent or worsening gagging
- Change in quality or pitch of voice
- Snoring
- Other problems:

**Yes No Cardio-Respiratory**

- Breathing problems
- Wheezing
- Coughing
- Apnea (breathing stops)
- Blueness around the mouth
- Heart murmur
- Chest pain

**Yes No Dental**

- Cavities
- Problems brushing teeth
- Has not seen dentist

**Yes No Sleep Problems**

- Sleeplessness
- Teeth grinding
- Excessive daytime sleepiness
- Sleepwalking
- Nightmares

**Yes No Psychiatric**

- Severe mood swings       Depression
- Severe behavior           Other

**Review of Neurological System**

**Yes      No**

- Dizziness with exercise \_\_\_\_\_
- Neck or back pain \_\_\_\_\_
- Numbness or tingling \_\_\_\_\_
- Dizziness or light-headedness \_\_\_\_\_
- Fainting \_\_\_\_\_
- Seizures \_\_\_\_\_
- Staring spells \_\_\_\_\_
- Tremors \_\_\_\_\_
- Problems with balance \_\_\_\_\_
- Change in strength or coordination \_\_\_\_\_
- Change in gait or walk \_\_\_\_\_
- Confusion or disorientation \_\_\_\_\_
- Change in behavior \_\_\_\_\_
- Change in school performance \_\_\_\_\_
- Problems with concentration \_\_\_\_\_
- Problems with memory \_\_\_\_\_
- Problems with understanding speech \_\_\_\_\_
- Prior head injury with or without loss of consciousness \_\_\_\_\_
- Prior neck injury \_\_\_\_\_
- Problems with continence, Urinary or Fecal or Both: \_\_\_\_\_
- Prior trauma or abuse \_\_\_\_\_
- Headaches \_\_\_\_\_







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|                        |
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Form completed by  
Signature & Printed Name: \_\_\_\_\_ Date & Time: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Printed Name: \_\_\_\_\_

