

Initial History Questionnaire		Name			
FORM COMPLETED BY	DATE COMPLETED	BIRTH DATE	AGE	M	F

Household

Please list all those living in the child's home

Name	Relationship to child	Birth date	Health problems	Are there siblings not listed? If so, please list their names and ages and where they live.
				If mother and father are not living together or if child does not live with parents, what is the child's custody status?
				If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home?

Birth History

Birth Weight	Was the delivery <input type="checkbox"/> vaginal? <input type="checkbox"/> cesarean?
Was the baby born at term? Early? Late?	If cesarean, why:
If early, how many weeks gestation?	Did your baby have any problems right after birth?
Did mother have any illness or problem with her pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain
	Was initial feeding <input type="checkbox"/> Breast? <input type="checkbox"/> bottle?
During pregnancy, did mother: Smoke <input type="checkbox"/> Yes <input type="checkbox"/> No Drink Alcohol <input type="checkbox"/> yes <input type="checkbox"/> no	Did your baby go home with mother from the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain
Use drugs or medications <input type="checkbox"/> Yes <input type="checkbox"/> No	
What When	

General

Do you consider your child to be in good health? Yes No Explain _____

Does your child have any serious illness or medical condition? Yes No Explain _____

Has your child had serious injuries or accidents? Yes No Explain _____

Has your child had any surgery? Yes No Explain _____

Has your child ever been hospitalized? Yes No Explain _____

Is your child allergic to any medicines or drugs? Yes No Explain _____

Development

Are you concerned about your child's physical development? Yes No Explain _____

Are you concerned about your child's mental or emotional development? Yes No Explain _____

Are you concerned about your child's attention span? Yes No Explain _____

If your child is in school:

How is his/her behavior in school? Yes No Explain _____

Has he/she failed or repeated a grade in school? Yes No Explain _____

How is he/she doing in academic subject? Yes No Explain _____

Is he/she in special or resource classes? Yes No Explain _____

