P: 973-326-9000 | F: 973-326-9001

Patient's Name: ______________________________ Birthdate: ______________

Who Brought/Is Bringing Child to the Visit: ______________ Date of Appointment: ____________

CHIEF COMPLAINTS

Why is the child here today? ____

BIRTH HISTORY

☐ *Check here if unknown.*

Was the baby born at full term? ☐ Yes ☐ No (*If NO, at how many weeks/months?* ____________)

Birth weight of baby: ____________

How was the baby delivered? ☐ Vaginal delivery ☐ Caesarean section / C-section
(*If Caesarean section/C-section, please explain why* ______________________________)

Did the mother use any tobacco, alcohol, drugs, or medications during pregnancy? ☐ Yes ☐ No
(*If YES, please list and describe* ______________________________)

Were there any complications during pregnancy, during birth, or after birth? ☐ Yes ☐ No
(*If YES, please explain* ______________________________)

Was a NICU (Neonatal Intensive Care Unit) stay required? ☐ Yes ☐ No
(*If YES, please explain why and what happened during the NICU stay* ______________________________)

Did the baby go home with the mother from the hospital? ☐ Yes ☐ No
(*If NO, please explain* ______________________________)

MEDICAL HISTORY/REVIEW OF SYSTEMS

Does your child have, or has your child ever had:

Hospitalizations	☐ Yes	☐ No	Explain:
Anxiety	☐ Yes	☐ No	Explain:
Any heart problems or heart murmur	☐ Yes	☐ No	Explain:
Asthma, bronchitis, or pneumonia	☐ Yes	☐ No	Explain:
Constipation	☐ Yes	☐ No	Explain:
Depression	☐ Yes	☐ No	Explain:
Difficulty focusing or paying attention	☐ Yes	☐ No	Explain:
Fainting spells	☐ Yes	☐ No	Explain:
Frequent ear infections	☐ Yes	☐ No	Explain:
Frequent sore throats	☐ Yes	☐ No	Explain:
Hyperactivity	☐ Yes	☐ No	Explain:
Mood disorder	☐ Yes	☐ No	Explain:
Problems with ears or hearing	☐ Yes	☐ No	Explain:
Problems with eyes or vision	☐ Yes	☐ No	Explain:
Seizures	☐ Yes	☐ No	Explain:
Sleep walking	☐ Yes	☐ No	Explain:
Snoring	☐ Yes	☐ No	Explain:
Staring spells	☐ Yes	☐ No	Explain:
Trouble falling asleep	☐ Yes	☐ No	Explain:
Turning blue around the mouth	☐ Yes	☐ No	Explain:

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SURGICAL HISTORY

☐ *Check here if unknown.*

Has your child ever had surgery? ☐ Yes ☐ No

(*If YES, what surgery did he/she have and when was the surgery?* ____
____)

BIOLOGICAL FAMILY HISTORY

☐ *Check here if unknown.*

Have any biological family member had the following?

ADHD	☐ Yes	☐ No	Who:
Anxiety	☐ Yes	☐ No	Who:
Autism spectrum disorder	☐ Yes	☐ No	Who:
Cerebral palsy	☐ Yes	☐ No	Who:
Depression	☐ Yes	☐ No	Who:
Developmental delay	☐ Yes	☐ No	Who:
Genetic disorders (e.g. Downs syndrome)	☐ Yes	☐ No	Who:
Headaches or migraines	☐ Yes	☐ No	Who:
Learning problems	☐ Yes	☐ No	Who:
Lupus or other autoimmune diseases	☐ Yes	☐ No	Who:
Multiple sclerosis	☐ Yes	☐ No	Who:
Seizures	☐ Yes	☐ No	Who:
Stroke	☐ Yes	☐ No	Who:
Tics or Tourette syndrome	☐ Yes	☐ No	Who:
Other psychiatric illness	☐ Yes	☐ No	Who:

From what city and country are the child's biological mother and father?

Mother: ______________________________ Father: ______________________________

Are the biological mother and father related/from the same family? ☐ Yes ☐ No

SOCIAL HISTORY

Please list *all* those living in the child's home:

NAME	Date of Birth	Age	Relationship to Child

Which of these best describes the child's living situation?

☐ Lives with both biological parents
☐ Lives with one biological parent (but *joint* custody)
☐ Lives with foster family
☐ Lives with adoptive parents
☐ Lives with one biological parent (*sole* custody)
☐ *Other*: ______________________

Does anyone in the home smoke? ☐ Yes ☐ No

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SCHOOL/ACADEMIC HISTORY

Please list *all* schools that your child has attended.

NAME OF SCHOOL	Grades (or Years)

Please list most recent grades or performance in the following subjects:

NAME OF SUBJECT	Grade or Performance
Language Arts	
Mathematics	
Science	
Social Studies	
Other	

Did the child ever repeat a grade at school? ☐ Yes ☐ No
(*If YES, why and which grades?* ____
____)

Did the child ever have a Child Study Team evaluation? ☐ Yes ☐ No
(*If YES, why and what were the results?* ____
____
____)

****If your child has ever had a Child Study Team (CST) evaluation and/or Individualized Education Program (IEP), be sure to bring an updated copy to the examination****

Is your child receiving special accommodations at school? ☐ Yes ☐ No
(*If YES, what accommodations?* ____
____)

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DEVELOPMENTAL HISTORY

☐ *Check here if unknown.*

Has your child every regressed (that is, lost or forgot developmental skills)? ☐ Yes ☐ No

(*If YES, please describe what happened* ______________________________)

Around how old was your child when he/she was consistently able to:

Sit up unassisted	Age: ____________	☐ Unable to do this
Crawl	Age: ____________	☐ Unable to do this
Walk a few steps unassisted	Age: ____________	☐ Unable to do this
Say his/her first words	Age: ____________	☐ Unable to do this
Speak in phrases	Age: ____________	☐ Unable to do this

Has your child ever received developmental therapies? ☐ Yes ☐ No

If YES, which therapies?

☐ Physical therapy ☐ Occupational therapy ☐ Applied Behavioral Analysis (ABA)

☐ Speech therapy ☐ Social skills therapy ☐ Psychological/Behavioral therapy

MEDICATIONS

☐ *Check here if unknown.*

Please list all of your child's current medications, including vitamins or supplements.

NAME OF MEDICATION	DOSAGE AND TIMING OF MEDICATION

ALLERGIES

☐ *Check here if unknown.*

Has your child ever had an allergic reaction to medication? ☐ Yes ☐ No

(*If YES, what medication(s) and what was/were the allergic reaction(s)?* ______________________________

____

______________________________)

Has your child ever had an allergic reaction to food? ☐ Yes ☐ No

(*If YES, what foods(s) and what was/were the allergic reaction(s)?* ______________________________

____

______________________________)

Does your child have seasonal allergies? ☐ Yes ☐ No

IMMUNIZATIONS

☐ *Check here if unknown.*

Is your child up-to-date on all immunizations? ☐ Yes ☐ No

(*If NO, please explain why:* ______________________________

______________________________)