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Child's Name:		**Date of Birth:**	
Address:		**Child's primary language:**	
City:			

PARENT / GUARDIAN

Name of individual(s) who has legal custody of child:	
If cared for by guardian, how long has child been in your care?	

Mother's Name:		**Father's Name:**	
Occupation / Employer:		Occupation / Employer:	
Phone Number:		Phone Number:	
Education/Schooling:		Education/Schooling:	
Address (if different from child)		Address (if different from child)	

If one or both parents do not live with child, what is their level of involvement with him or her? _____

HOME

What languages are spoken in the home?	
What other adults live within the child's home?	

SIBLINGS / OTHERS (including stepparents, step-siblings, or half-siblings)

	Name	Age	Relationship to Child	Does he/she live in the home?
1				
2				
3				
4				
5				
6				

FAMILY

Has child experienced any significant changes (e.g., parental separations, divorces, death, birth of sibling, illnesses, etc)?	

Any history within the biological family (brothers, sisters, parents, grandparents, aunts, uncles, etc) of:

		Please Specify Below ↓
☐	Learning problems / special-education services	
☐	Speech/language therapy services	
☐	Mental health diagnoses (please specify)	
☐	Drug/alcohol addiction	
☐	Anxiety or depression	
☐	Attention Deficit-Hyperactivity Disorder (ADHD)	
☐	Hard of Hearing / Deaf	
☐	Intellectual Deficiency (Mental Retardation)	
☐	Other (please specify)	

Please answer thoroughly and return as soon as possible

PREGNANCY & BIRTH

Birth weight: _____ lbs _____ ounces Length of pregnancy _____ (in weeks)

Was delivery? ☐ Vaginal ☐ Cesarean-section

Where was child born: _____

Complications during pregnancy? ☐ Yes ☐ No → If yes, please explain _____

Complications during delivery? ☐ Yes ☐ No → If yes, please explain _____

During pregnancy, did mother:
Use alcohol ☐ Yes ☐ No Smoke ☐ Yes ☐ No
Take Medications ☐ Yes ☐ No Use drugs ☐ Yes ☐ No
(please explain) _____

Did child require NICU Care? ☐ Yes ☐ No → If yes, please explain _____

Has child had a newborn hearing screening? ☐ Yes ☐ No
If yes, did child pass the screening? ☐ Yes ☐ No

MEDICAL

Pediatrician: _____

Describe child's present health: _____

Is child under care of other physicians? ☐ Yes ☐ No (If yes, please list below)

Physician Name	Type of Physician (e.g., cardiologist)

Does child have a medical diagnosis? ☐ Yes ☐ No (If yes, please list below)

Is child prescribed medications? ☐ Yes ☐ No (If yes, please list below)

Name of Medication(s)	Reason for Medication

Are immunizations up-to-date? ☐ Yes ☐ No
Tested for lead? ☐ Yes ☐ No Are results within normal limits? ☐ Yes ☐ No
If lead testing is ***not*** within normal limits, what is child's current lead score? _____

Any history of: ☐ Medical problems ☐ Hospitalizations ☐ Injuries
☐ Special needs ☐ Surgeries ☐ Significant Illnesses

If yes, please explain →

Description of Medical Incident	Date of Incident

Has child experienced any of the following: →

Ear Infections ☐ Yes ☐ No If yes, about how many? _____
Allergies ☐ Yes ☐ No If yes, please explain: _____
Seizures ☐ Yes ☐ No
High Fevers ☐ Yes ☐ No

Has child had PE tubes? ☐ Yes ☐ No If yes → How many times were tubes inserted? _____
What date(s) were tubes inserted? _____

Hearing problems? ☐ Yes ☐ No Has child had hearing tested? ☐ Yes ☐ No
If so, when? Results: _____

Vision problems? ☐ Yes ☐ No Has child had vision tested? ☐ Yes ☐ No
If so, when? _____ Results: _____

How many hours does child sleep at night? _____ Does child nap? _____
Any sleep concerns?

DEVELOPMENT

Overall, did your child's development appear: ☐ Average ☐ Early ☐ Late

At approximately what age did child first do the following:

	Coo / babble		Crawl		Feed self with fingers
	Smile		Walk		Feed self with utensils
	Roll over		Speak single words		Toilet-trained during the day
	Sit up		Speak in phrases		Toilet-trained during the night

Describe child's eating habits _____

Describe child's self-help skills (feeding, dressing, etc.) _____

EDUCATION

Has child attended a preschool or daycare program? ☐ Yes ☐ No (If yes, please list below)

Name of Preschool or Daycare	Estimated Date(s) of Attendance	Describe School Experience

Was child previously evaluated through Early Intervention or the Committee on Preschool Special Education?
☐ Yes If yes → Approximate date of evaluation: _____
☐ No Did child receive any services?: _____

PRESENT FUNCTIONING

Child's strengths: _____

Areas of concern: _____

Please check areas of concern that may apply:			
➢ **Speech-Language**	☐ Speech difficult to understand	☐ Understanding verbal questions/directions	☐ Using words to express wants/needs
➢ **Social-Emotional**	☐ Interaction with others	☐ Play skills	☐ Coping skills
➢ **Adaptive Self-Help**	☐ Dressing self	☐ Feeding self	☐ Toileting
➢ **Behaviors**	☐ Aggressive ☐ Withdrawn	☐ Maintaining attention ☐ Overly active	☐ Anxious ☐ Easily upset/frustrated
➢ **Cognitive/Learning**	☐ Thinking, reasoning, problem-solving skills	☐ Learning educational concepts (e.g., colors)	
➢ **Motor**	☐ Coordinating hands to complete tasks (e.g., grasping objects)	☐ Maneuvering whole body (e.g., running, climbing, throwing)	
Additional information:			

How does child interact with others? (e.g., interest towards playing with others, turn-taking, sharing): _____

Additional Comments: _____

Parent/Guardian Signature: _____ Date _____

Clinician Signature: _____ Date: _____

Please answer thoroughly and return as soon as possible