

**PEDIATRICS**  
**CONFIDENTIAL HEALTH HISTORY**

Today's Date \_\_\_\_\_

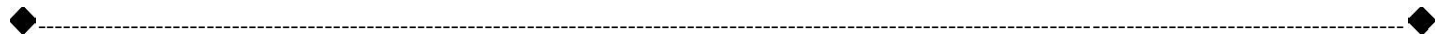
**Dear Patient:** This information is considered confidential. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Last: \_\_\_\_\_ First: \_\_\_\_\_ DOB: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Mental Health Professional: \_\_\_\_\_

Height: \_\_\_ Weight: \_\_\_ Premature: \_\_\_ Adopted: \_\_\_\_\_ Foster: \_\_\_\_\_

Age started talking? \_\_\_\_\_ Age started crawling? \_\_\_\_\_ Age started walking? \_\_\_\_\_



Your Primary Concern Today:

\_\_\_\_\_

Medications: \_\_\_\_\_ Allergies: \_\_\_\_\_

Hospitalizations /Medical conditions: \_\_\_\_\_

Past Therapy Services: \_\_\_\_\_

IFSP or IEP? Yes No Vision Screening? Pass Fail Unknown Hearing Screening? Pass Fail Unknown

Does your child spend time out of the home (preschool, grandparents, respite) If yes, explain: \_\_\_\_\_

\_\_\_\_\_

**Please answer the following questions based on how you describe your child on most days:**

Does your child "get hungry?" \_\_\_\_\_ Gags when eating? \_\_\_\_\_ A "Picky Eater?" \_\_\_\_\_

Does your child fall asleep easily? \_\_\_\_\_ Stay Asleep all night? \_\_\_\_\_ Wake looking rested? \_\_\_\_\_

Is your child potty trained? \_\_\_\_\_ Frequent stomach aches? \_\_\_\_\_ Constipation? \_\_\_\_\_ Diarrhea? \_\_\_\_\_

Does your child get headaches? \_\_\_\_\_ Not always respond to their name? \_\_\_\_\_ Appear Clumsy? \_\_\_\_\_

Likes bath? \_\_\_\_\_ Gets ready in am with no problem? \_\_\_\_\_ Gets ready in pm with no problem? \_\_\_\_\_

Shy or Withdrawn? \_\_\_\_\_ Overly affectionate? ( may hug people they don't know) \_\_\_\_\_

Ever have Physical Outbursts? \_\_\_\_\_ Verbal Outbursts? \_\_\_\_\_ Struggles with friendships? \_\_\_\_\_

**Please explain any additions concerns:** \_\_\_\_\_

**Please list strengths in your child and any other information you would like us to know:** \_\_\_\_\_