

PEDIATRIC HISTORY

DATE _____

CHILD'S NAME _____ AGE _____ GRADE _____

PARENT'S NAME(S): _____

WHO REFERRED YOU TO US? _____

DESCRIBE YOUR CHILD'S PROBLEM: _____

DO YOU HAVE CONCERNS ABOUT HOW YOUR CHILD HEARS?
DESCRIBE: _____

DOES YOUR CHILD:	YES	NO
A. Respond if you call him/her from another room	___	___
B. Respond to his/her name?	___	___
C. Try to look toward the sound source when a noise is made?	___	___
C. Alert to familiar sounds—for example a spoon in a cup?	___	___
D. Stop what he/she is doing when there is an unfamiliar sound?	___	___

DO YOU HAVE ANY CONCERNS ABOUT HOW YOUR CHILD TALKS?
DESCRIBE: _____

DOES YOUR CHILD:	YES	NO
A. Say at least 10 words?	___	___
B. Say 2-3 word sentences?	___	___
C. Speak clearly to the family?	___	___

NAME OF CHILD'S SCHOOL: _____

DO YOU HAVE CONCERNS ABOUT YOUR CHILD'S BEHAVIOR (TANTRUMS, HITTING, WILL NOT FOLLOW DIRECTIONS, ETC.) AT SCHOOL, HOME OR IN THE NEIGHBORHOOD?
DESCRIBE: _____

IS YOUR CHILD HAVING ANY PROBLEMS LEARNING AT SCHOOL?
DESCRIBE: _____

DO YOU NOTE ANY PROBLEMS WITH YOUR CHILD'S GENERAL DEVELOPMENT?
DESCRIBE: _____

AT APPROXIMATELY WHAT AGE DID YOUR CHILD:

- | | | |
|--------------------|----------------|-------------------------|
| A. ROLL OVER _____ | C. CRAWL _____ | E. SAY FIRST WORD _____ |
| B. SIT UP _____ | D. WALK _____ | F. TOLIET TRAIN _____ |

ARE THERE ANY PROBLEMS WITH YOUR CHILD'S GENERAL HEALTH (PLEASE INCLUDE EAR INFECTION HISTORY)?

DESCRIBE _____
