

INITIAL HISTORY QUESTIONNAIRE

Name _____ Birth Date _____ Age _____ Male _____ Female _____

Form Completed by _____ Date _____

HOUSEHOLD

Please list all those living in the child's home

Name	Relationship	Birth Date	Health Problems	Are there siblings not listed? If yes, please list their names and ages and where they are _____

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 baby born at <input type="checkbox"/> Term <input type="checkbox"/> Early <input type="checkbox"/> Late If early, how many weeks gestation? _____ Did mother have any illness or problem with her pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ <hr/> During pregnancy did mother smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No Drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Use Drugs or medications? <input type="checkbox"/> Yes <input type="checkbox"/> No What? _____ When? _____	Was the delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean If Cesarean, why? _____ <hr/> Did your baby have any problems right after birth? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ <hr/> Was initial feeding <input type="checkbox"/> Breast <input type="checkbox"/> Bottle Did your baby go home with mother from the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ _____ _____ _____
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GENERAL

Do you consider your child to be in good health?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain
Does your child have any serious illness or medical condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain
Has your child had serious injuries or accidents?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain
Has your child had any surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain
Has your child ever been hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain
Is your child allergic to any medicines or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain

DEVELOPMENT

Are you concerned about your child's physical development?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain
Are you concerned about your child's mental or emotional development?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain
Are you concerned about your child's attention span?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain
If your child is in school: _____	
How is his/her behavior in school? _____	
Has he/she failed or repeated a grade in school? _____	
How is he/she doing in academic subjects? _____	
Is he/she in special or resource classes? _____	

