Patient Name_____DOB_____

Orchid Pediatrics

CHILD HISTORY FORM (optional)

Many parents find that completing this form helps them organize information that is relevant to their child's difficulties. Completion of this form can also help increase the efficiency of the first visit, thereby decreasing cost. Please feel free to complete as much (or as little!) of the form as you feel will be helpful. If there is insufficient space for a complete response, feel free to add additional pages (please note on this form that you have included information on a separate page).

PARENT/GUARDIAN CONCERNS:

What are your main concerns regarding your child at this time?

What would you like your child to gain from our services?

If your child has been evaluated for developmental or behavioral concerns in the past, describe the nature of the evaluation(s), dates performed, and any school/medical professionals involved.

DEVELOPMENTAL CONCERNS:

Do you have concerns about your child's development in any of the following areas? Please circle any that apply:

Gross Motor Development	Fine Motor Development	Speech/ Language Development
Handwriting	Self Care Skills	Social Communication
Social Skills/Behavior	Attention	Sleeping
Sensory Processing Skills	Play	Eating
Toileting	Other (please describe):_____	

PREGNANCY & BIRTH HISTORY

Was pregnancy planned? yes / no When did prenatal care begin? _____

Any difficulties with conception? (ie IVF, donated egg or sperm, surrogacy) yes / no

If yes, please describe:_____

Who are the biological parents? _____

List any complications, illnesses, and/or accidents during pregnancy/labor/delivery:

Patient Name_____DOB_____

CHILD HISTORY FORM, page 2

PREGNANCY & BIRTH HISTORY, CONTINUED

List any prescriptions taken during pregnancy:

Known substance exposures during pregnancy: cigarettes alcohol drugs marijuana environmental toxins

Type of delivery: **vaginal c-section** Forceps used? **yes no** Vacuum used? **yes no**

Was the baby premature? yes no Gestational age at birth: _____ weeks

Baby's birth weight: Apgar scores (if known):

Was your child in the NICU? yes no If yes, how long?

Describe your initial bonding experience with your child:

Did either parent experience the "baby blues" (postpartum depressions)? yes no If yes, did they receive treatment? Please describe:

Describe any prolonged separations from parent(s) during infancy:

CHILD'S GENERAL HEALTH

Please describe the general state of your child's health:_____

_____

Please circle any of the following that are of concern to you:

General:	poor appetite	excessive appetite	excessive thirst
	overweight	underweight	difficulty sleeping
	excessive sleeping	confusion	fever
	loss of memory	no energy	behavior problems
	excessive energy		
Eyes:	eye pain	blurred vision	crossed eyes
	seen by eye doctor	eye itching	vision complaints
ENMT:	ear pain	hearing loss	loud snoring
	tooth pain	congestion	sneezing
	sore throat	bloody nose	
Respiratory:	hoarseness	persistent cough	wheezing
	difficulty breathing	exercise intolerance	

Patient Name_____DOB_____

CHILD HISTORY FORM, page 3

CHILD'S GENERAL HEALTH, CONTINUED

Please circle any of the following that are of concern to you:

Cardiovascular:	fatigue	chest pain	palpitations
	heart murmur	blue spells	fainting spells
Gastrointestinal:	abdominal pain	nausea	vomiting
	diarrhea	blood in stool	constipation
	stool in underwear	pain after eating	
Urinary:	painful urination	frequent urination	abnormal urine stream
	daytime wetting	bed wetting	urine color _____
	burning with urination	toilet trained	
Skeletal:	bone pain	joint pain	muscle pain
	weakness	back pain	swollen joints
	frequent fractures/breaks		
Neuromuscular:	headache	migraine	numbness
	loss of coordination	loss of balance	dizziness
	seizure	delayed development	jerks
	unexplained movements	tics/motor habits	
Psychiatric:	explosive	defiant	anxious
	temper tantrums	phobias / fears	transition difficulty
	hitting / biting	clingy / needy	resistant to bathing
	hyper active	under active	obsessions
	compulsions	hallucinations	delusions
	depression	suicidal	grandiose ideation
	hypersexual	boundary issues	sexual identity issues
Skin:	rash / acne	unexplained bruising	birth marks
	Itchy skin		

☐ Any other health concerns? Please describe:

Has your child ever lost consciousness or experienced a significant head trauma? yes no Please describe:

Has your child been hospitalized? yes / no Overnight? yes / no

If yes, for what and when:

Date of last well child exam: _____ Are immunizations up-to-date? yes / no

Any adverse reactions to vaccines? yes / no If so, please describe:

Patient Name_____DOB_____

CHILD HISTORY FORM, page 4

List medications (including vitamins and supplements) your child currently takes on a regular basis and indicate the reason for taking them:

What medications has your child taken in the past?

List any medication, environmental and/or food allergies (include symptoms that result with each allergy):

MOTOR DEVELOPMENT

At what age did your child accomplish the following developmental milestones? If you don't recall, but there were no concerns, please note "no concerns."

Rolled over	
Sat alone	
Belly crawled	
Crawled	
Pulled to stand	
Walked	

Has your child developed hand dominance? **yes no** If yes, **right** or **left**?

Does your child avoid using one side of his/her body? **yes no**

Does your child tend to have difficulty learning new motor tasks? **yes no**

Is your child resistant to participation in motor tasks? **yes no**

Any concerns with clumsiness/lack of coordination now? **yes no** If yes, please describe:

Any concerns about handwriting or drawing skills? **yes no** If yes, please describe:

Any concerns about ability to complete age-appropriate self-care skills from a motor skill standpoint? (bathing, brushing teeth, feeding self, etc)? **yes no** If yes, please describe:

If your child has been seen by an occupational or physical therapist in the past, please indicate when and where:

Patient Name_____DOB_____

CHILD HISTORY FORM, page 5

SENSORY DEVELOPMENT:

Please note any difficulty with processing sensory information in the following areas: If unsure, note "unsure"

Tactile_____

Auditory_____

Olfactory_____

Visual_____

Taste_____

Vestibular_____

Proprioceptive:_____

EMOTIONAL REGULATION:

Check any of the behaviors below which describe your child's emotional regulation as an *infant*:

☐ Used to cry/fuss a lot ☐ Was "good"/not demanding ☐ Was alert ☐ Was quiet/passive

☐ Used to drool excessively ☐ Used to resist being held ☐ Was floppy when held ☐ Was tense when held

☐ Was very active ☐ Had poor sleep patterns ☐ other_____

Check any of the behaviors below which describe your child's emotional regulation *now*:

☐ Is overly active ☐ Tires easily ☐ Is impulsive ☐ Is restless ☐ Has difficulties with change/transitions

☐ Has frequent temper tantrums ☐ Over-reacts to non-threatening situations/activities

☐ Other_____

ADAPTIVE FUNCTIONING:

Does your child require more support than expected for their age to accomplish activities of daily living (such as bathing, dressing, washing hair, washing hands, feeding, toothbrushing), separate from having difficulty with the motor skills required? **yes no** If yes, please describe:

ACADEMIC DEVELOPMENT:

Do you have any concerns about your child's academic performance? **yes / no If yes, please describe:**

Location and date of any previous academic testing_____

Does your child receive help from a tutor? If so, which subjects?_____

Patient Name_____DOB_____

CHILD HISTORY FORM, page 6

SPEECH-LANGUAGE DEVELOPMENT

Give approximate ages when your child:

UNDERSTOOD LANGUAGE

Knew own name ☐ by 8 months OR ☐ after 8 months OR ☐ unsure but no concerns

Responded to "no" ☐ by 12 months OR ☐ after 12 months OR ☐ unsure but no concerns

Followed 1-step directions ☐ by 18 months OR ☐ after 18 months OR ☐ unsure but no concerns

Recognized names of familiar objects ☐ by14 months OR ☐ after 14 months OR ☐ unsure but no concerns

Pointed to common pictures named ☐ by 18 months ☐ after 18 months OR ☐ unsure but no concerns

Answered "yes/no" questions ☐ by 18 months OR ☐ after 18 months OR ☐ unsure but no concerns

PRODUCED SPEECH-LANGUAGE

Began babbling ("ba-ba-ba") ☐ by 8 months OR ☐ after 8 months OR ☐ unsure but no concerns

Began to imitate sounds ☐ by 8 months OR ☐ after 8 months OR ☐ unsure but no concerns

Used first word ☐ by 14 months OR ☐ after 14 months OR ☐ unsure but no concerns

Had vocabulary of 10 words ☐ by 18 months OR ☐ after 18 months OR ☐ unsure but no concerns

Used 50 spontaneous words ☐ by 24 months OR ☐ after 24 months OR ☐ unsure but no concerns

Put 2 words together ☐ by 24 months OR ☐ after 24 months OR ☐ unsure but no concerns

Describe how your child lets you know what he/she wants or needs (or note " no concerns"):

List three sample sentences, phrases, or words your child currently uses (or note "no concerns"):

Approximately how much of what your child says do you understand (percent)?

☐none ☐ 10% ☐ 30% ☐ 50% ☐ 70% ☐ 90% ☐100%

Approximately how much of what your child says do unfamiliar listeners understand (percent)?

☐none ☐ 10% ☐ 30% ☐ 50% ☐ 70% ☐ 90% ☐100%

Please describe any concerns about social communication:

Does your child stutter or repeat words? **yes no** Make repetitive sounds for no obvious reason? **yes no**

If yes, please describe:

If your child has been seen by a speech therapist in the past, please indicate when and where:

Patient Name_____DOB_____

CHILD HISTORY FORM, page 7

PLAY:

What does your child enjoy doing in his/her free time?

HEARING

Do you feel or has it been suggested that your child has difficulty hearing? yes / no If yes, please describe:

Has your child's hearing been tested? yes / no

If yes, when?_____ Where?_____Results:_____

Is there a family history of childhood hearing loss? yes / no If yes, who? _____

Does your child have a history of ear infections? yes / no If yes, describe frequency:_____

How were your child's ear infections treated? _____

Has your child seen an Ear Nose & Throat doctor (ENT)? yes / no If yes, who?_____

Has your child had surgery on his/her ears? yes no

If yes, what kind and when?_____

Did/does your child wear hearing aids? yes / no cochlear implant? yes / no If so which ear/ears? left right

Make and model:_____

VISION DEVELOPMENT:

Do you have any concerns about your child's vision? yes / no If yes, please describe:

Location and date of any previous vision evaluation_____

Any history of vision therapy? yes / no If yes, where and when?_____

GENDER IDENTITY DEVELOPMENT:

With what gender does your child identify? male female other

Any concerns about gender identity? yes no

MEDIA/SCREEN USE:

Please note total daily hours of screen time. Weekday #hours/day_____ Weekend #hours/day_____

Describe type and amount of screen time (ie, TV vs phone vs tablet vs computer, and what type of programs are viewed on each media type):

Patient Name_____DOB_____

CHILD HISTORY FORM, page 8

TOILETING/ELIMINATION:

Is your child currently toilet-trained? yes / no If yes, since what age?_____

What is your child's typical bowel pattern? ____ time(s) a day.

Does your child experience: ☐ daytime accidents ☐ bedwetting ☐ constipation ☐ frequent loose stools ☐ unusually foul odor to stools

Did your child toilet train easily? yes no If not, please describe:

FEEDING:

Give approximate ages when your child:

Ate solid foods_____(or circle: unsure but no concerns)

Drank from open cup, unassisted:_____ (or circle: unsure but no concerns)

Fed self with fingers:_____ (or circle: unsure but no concerns)

Fed self with utensils:_____ (or circle: unsure but no concerns)

Did your child explore toys orally as an infant? yes no

Was your child breast-fed? yes no If yes, how long? Bottle-fed? yes no If yes, how long?

Any problems with breast or bottle-feeding? yes no If yes, please explain

Describe any feeding difficulties (past/present):

Does your child currently use a bottle or sippy cup? yes no or pacifier? yes no
Current appetite (please circle one): poor fair good

Check any feeding difficulties your child has now, or had in the past ☐ sucking ☐ chewing ☐ choking ☐ swallowing ☐ accepting new foods ☐ over-stuffing mouth ☐ strong likes/dislikes for certain foods ☐ picky ☐ overeats ☐ refuses to eat ☐ hoards food ☐ gags/vomits ☐ eats non-food items
☐ Other:

Does your family eat together at least once a day? yes no

Does your child remain seated at the table throughout the meal? yes no

Does your child experience significant drooling? yes no

Does your child tolerate toothbrushing well? yes no

How is your child's food prepared? ☐ Whole foods ☐ cut up ☐ chopped ☐ fork mashed ☐ puree

Please describe your child's diet, including any food allergies, aversions/picky eating or special diet (past or present):

Patient Name_____DOB_____

CHILD HISTORY FORM, page 9

SLEEP:

Where does the child sleep ☐ solo (own bed) ☐ with parent ☐ with sibling

Does s/he sleep in a room alone or share a room with sibling/other?_____

Bedtime: _____ Average number of hours of sleep each night?_____

Naps? yes no If yes, for how long?_____

Sleep disturbances: ☐ reluctance to go to bed ☐ restless during the night ☐ bad dreams ☐ frequent waking ☐ difficulty in getting to sleep ☐ talks/cries in sleep ☐ snoring/irregular breathing ☐ difficulty getting up in the morning ☐ other concerns related to sleep behaviors (please describe):

FAMILY HISTORY

Please note any family history of the following, especially in siblings, parents, aunts, uncles, cousins or grandparents (please include how the person is related to your child with each positive response – ie maternal aunt, paternal grandfather):

Heart problems (especially under age 60):_____
-ie heart attack, arrythmia, congenital heart disease, sudden cardiac death, valve problems

Lung problems:_____
-ie asthma, cystic fibrosis, other breathing problems

Kidney problems:_____
-ie recurrent urinary or kidney infections, kidney stones, kidney failure, abnormalities of the kidney

Liver problems:_____
-ie hepatitis (infectious or autoimmune), other diseases impacting liver function

Skin problems:_____
-ie eczema, psoriasis, vitiligo

Gastrointestinal problems:_____
-ie constipation, diarrhea, celiac disease, Inflammatory Bowel Disease, Chron's Disease, Ulcerative Colitis, irritable bowel, SIBO

Neurologic problems:_____
-ie seizures, movement disorders, multiple sclerosis, Tourette's Syndrome or tics, cerebral palsy

Allergies:_____
-ie to foods, environmental, medication or other

Immune problems (including autoimmune):_____
-ie Type 1 Diabetes, rheumatoid arthritis, thyroid disease, frequent infections, or more severe infections than expected when sick, other autoimmune diseases

Bleeding problems:_____
-ie easy bruising/bleeding, hemophilia, VonWIllebrand's

Cancer:_____
-especially in people less than 50yo

Patient Name_____DOB_____

CHILD HISTORY FORM, page 10

FAMILY HISTORY, CONTINUED

Psychiatric diagnosis OR SYMPTOMS:_____
-ie diagnosis or symptoms of autism, Asperger's, depression, anxiety, OCD, ADHD, ADD, bipolar/manic-depression, schizophrenia, personality disorders

Other_____
-ie any other medical or mental health condition not already described above

SOCIAL HISTORY

What activities does your family most enjoy doing together?

What kids of supports do you have? (ie family, friends, spiritual, community or government programs/services, babysitters/caregivers)

What are the major stressors for your family?
(ie job stress, impact of child's special needs/behavior on family, stress in relationship between parents/caregivers, financial stressors, mental/physical health difficulties of other family members, needs of extended family, relational stressors with extended family/friends, lack of support from family/friends)

What do parents do for work? (note: being a full time caregiver is very important work!)

LABS/IMAGING/EKG:

Have labs or imaging or EKG ever been done? If so, please indicate where and when (if you have copies of results, please include them with this form):

OTHER TESTING/EVALUATIONS:

Please list any other testing/reports/evaluations not already described (if you have copies of results, please include them with this form):