PEDIATRIC HISTORY FORM

Date: _____

Client's Name:	**DOB:**
Gender:	**HEALTH CARD #:**
Person Completing Form:	**Relationship to Student:**

Living Situation:

- **Is child living with both parents?:** _____ **yes** _____ **no**
- **If no, who is the child living with?** _____

☐ **Natural home** ☐ **Foster Home** ☐ **Other (specify)** _____

Siblings	Ages	Sex	Grade	Speech, Hearing, Learning, Physical and/or Medical Problems	Who is living in the home?

Is there anyone else living in the home?

Is there a social worker involved? ❒ yes ❒ no

If so, who is the current social worker for this child:

Social Services Office/Location:

Are the biological parents: ❒ Together ❒ Separated ❒ Divorced ❒ Single

If the parents are separated or divorced, what is the custody arrangement for this child?

Parent/Guardian Information

Biological Mother's Name:		**Email:**
Address:		
Home #:	**Cell#**	**Work#**
Biological Father's Name:		**Email:**
Address:		
Home #:	**Cell#**	**Work#**
Guardian (if applicable):		**Email:**
Address:		
Home #:	**Cell#**	**Work#**:

Where does the child spend the day? ❒ Home ❒ Babysitter ❒ Daycare ❒ Preschool ❒ Pre-Kindergarten

Daycare/Play School/Pre-K attending:

Reason for Referral

Reason for Referral (Please describe your concern[s] regarding your child's development):

Speech and Language: _____

Motor Skills (coloring, jumping, balancing, throwing etc.) : _____

_____

Social skills: _____

Development: _____

Other: _____

Strengths Identification

What do you consider your child's strengths to be:

Pregnancy History

Length of pregnancy (weeks): **Birth Weight**: lbs. oz.

Child's length of stay in hospital:

Pregnancy complications (eg. diabetes, high blood pressure, etc.)**:**

Labour complications (eg. c-section, assisted delivery, etc):

Describe your child in the first hour after delivery (eg. colour, breathing, oxygen - did they need help breathing?):

Describe your lifestyle in the 6 months before your pregnancy:

Alcohol used during pregnancy? ❒ yes ❒ no **If yes, please describe**:

Cigarettes used during pregnancy? ❒ yes ❒ no **If yes, please describe**:

Other drugs used during pregnancy? (Prescription and/or recreational, [Marijuana, cocaine, hashish, etc.])
❒ yes ❒ no **If yes, please describe**:

Medical History (please check and/or circle all that apply)

Ear infections: ❒ rare ❒ often	❒ hearing loss	❒ heart problems
If so, how many? _____	❒ wears hearing aids	❒ allergies to _____
❒ tubes in ears	❒ Cleft Lip / ❒ Cleft Palate	❒ convulsions/seizures
❒ Tonsillitis / ❒ Tonsillectomy	❒ difficulty swallowing	❒ Adenoids
❒ Laryngitis (harsh voice)	❒ Meningitis	❒ Sleep Patterns
❒ Bronchitis	❒ vision problems	❒ Gagging
❒ Pneumonia	❒ dental problems	❒ Choking
❒ Asthma	❒ brain injury	❒ Other
❒ frequent colds	❒ Encephalitis	
❒ high fever	❒ HIV / Aids	

Have there been any medical tests/procedures (eg. surgeries, CT scans, MRI, X-rays, etc.)?

Is your child currently under the care of a doctor? ❒ Yes ❒ No

If yes who? _____

Does your child have a medical diagnosis and/or is he/she in the process of obtaining one? If yes please provide details:

_____

_____

_____

_____

Does your child currently take prescription medication? ❒ yes ❒ no

If yes, please indicate what medications & for what reason:

Do you have any medical concerns for your child? ❒ Yes ❒ No

If yes, what are your concerns? _____

_____

Do you have any concerns regarding your child's hearing? ❒ yes ❒ no

If so, please describe:

Has your child ever had his/her hearing tested? ❒ yes ❒ no (If so, please indicate where and with whom?)

Has your child ever been to the dentist? ❒ Yes ❒ No

When: _____

Has your child ever had a vision test? ❒ Yes ❒ No

When: _____

Developmental Milestones/History - Please indicate year/months of age as ***best*** as you can.

Crawl - Age:	**Walk – Age:**
Age Bladder trained – Day _____ Night _____	**Age Bowel Trained – Day _____ Night _____**

Motor Development

Does your child use any assistive tools at home such as a walker, splints, speaking technology etc.?

Speech and Language Information

Did your child babble and make lots of noises/sounds before 1 year of age? ❒ yes ❒ no

What age did your child say his/her first word? What was the word?

What age did your child begin to combine words? (eg: hi mom; up dad, etc.)

What language(s) does your child understand? **Speak**?

When you talk to your child, how much does he/she seem to understand?

❒ a few words ❒ simple directions ❒ many words & phrases ❒ almost everything

How does your child usually let you know what he/she wants? Check all that apply:

❒ points to what he/she wants ❒ cries ❒ makes different sounds ❒ uses a few words/sounds

❒ uses only one word at a time ❒ uses two or three words together ❒ uses long sentences

How many words does your child usually use in a sentence? (please provide an example)

How much of your child's speech can you understand? ❒ all ❒ most ❒ some ❒ little/none

How much of your child's speech can others understand (people who don't see your child very often)?

❒ all ❒ most ❒ some ❒ little/none

Is your child aware of or frustrated by any speech-language difference? ❒ yes ❒ no

What is your impression of your child's learning abilities?

Social Development

Please indicate whether this child exhibits any of the following behaviors:

❒ prefers to play alone ❒ easily frustrated ❒ lacks self-control ❒ overactive

❒ tantrums frequently ❒ hides feelings ❒ cannot calm down ❒ withholds affection

❒ has short attention span/impulsive ❒ seems unhappy most of the time ❒ seems uncomfortable meeting new people

❒ has unusual fears**:** _____ ❒ difficulty separating from parents

Does your child play with toys similar to other children the same age? ❒ yes ❒ no

If not, please explain:

Does your child regularly play with children his/her own age? ❒ yes ❒ no

How does he/she play/interact with other children?

Who are your child's friends?

Agencies/Specialists Involved

Please give name of professional if possible.

❒ Alvin Buckwold Child Development Program (KCC-Saskatoon) Specialist:
❒ Hearing testing/ Audiologist
❒ Occupational Therapy:
❒ Physiotherapy:
❒ Speech-Language Pathology:
❒ Early Childhood Psychologist:
❒ Ear/Nose/Throat Specialist:
❒ ECIP Worker (Battlefords/Meadow Lake area):
❒ Midwest Family Connections (Lloydminster area only):
❒ KidsFirst Worker:
❒ Glenrose Rehabilitation Hospital (Edmonton):
❒ Pediatrician:
❒ Family Physician:
❒ Social Worker:
❒ Previous School – Name of School
❒ Other

Additional relevant information:

Thank you for taking the time to fill out this form as it will help our therapist(s) to provide you with the best care. If you have any questions or concerns regarding this form, please contact your child's teacher.