NAME _____

SEX: [ ] MALE [ ] FEMALE	Race	SSN	D.O.B.

Please list all people in the household:

NAME	DATE OF BIRTH	OCCUPATION	EDUCATION
Father			
Mother			
Other			
Other			
Other			
Other			

Have there been any recent major changes or stresses in the child's life? [ ] YES [ ] NO

If YES, Explain

_____

_____

Does child go to a baby sitter, preschool or day care regularly? [ ] YES [ ] NO

BIRTH HISTORY:

Birth Weight _____Length_____Place_____

During the pregnancy did the mother see a doctor regularly? [ ] YES [ ] NO

(If YES, Explain) Explanation_____

Have any medical problems? [ ] YES [ ] NO _____
Smoke or drink? [ ] YES [ ] NO _____
Use any medications? [ ] YES [ ] NO _____
Use alcohol or other drugs? [ ] YES [ ] NO _____
Have problems with labor/delivery? [ ] YES [ ] NO _____
How long did the baby stay in the hospital after birth?

_____

PAST MEDICAL HISTORY:

Is the child's general health: [ ] GOOD [ ] FAIR [ ] POOR

Does the child have any allergies? [ ] YES [ ] NO

Is the child taking any medications? [ ] YES [ ] NO

(If YES, Explain) Explanation_____

Please list any hospitalizations, operations, serious illnesses or accidents with dates:

_____Date:_____

Has the child ever had any problems with the following. If YES, please explain.

Eyes/Vision	[ ] YES [ ] NO _____
Feet	[ ] YES [ ] NO _____
Digestion/Nutrition	[ ] YES [ ] NO _____
Ears/Hearing	[ ] YES [ ] NO _____
Urine/Kidneys	[ ] YES [ ] NO _____
Joints	[ ] YES [ ] NO _____
Skin	[ ] YES [ ] NO _____
Lungs	[ ] YES [ ] NO _____
Teeth	[ ] YES [ ] NO _____
Heart	[ ] YES [ ] NO _____
Seizures	[ ] YES [ ] NO _____
Repeated Infections	[ ] YES [ ] NO _____

FAMILY HISTORY

Have any of the child's brothers or sisters died? [ ] YES [ ] NO

If YES, give age and cause

_____

Have any of the child's blood relatives had the following diseases? If YES, please list family member.

Heart Disease	[ ] YES [ ] NO _____
Tuberculosis	[ ] YES [ ] NO _____
High Blood Pressure	[ ] YES [ ] NO _____
Kidney Disease	[ ] YES [ ] NO _____
Allergies/Asthma	[ ] YES [ ] NO _____
Cancer	[ ] YES [ ] NO _____
Diabetes	[ ] YES [ ] NO _____
Mental/Emotional Problems	[ ] YES [ ] NO _____
Sickle Cell	[ ] YES [ ] NO _____
Seizures	[ ] YES [ ] NO _____

DEVELOPMENT

Do you have any concerns about the following? If YES, please explain.

Development	[ ] YES [ ] NO _____
Behavior	[ ] YES [ ] NO _____
Eating Habits	[ ] YES [ ] NO _____
Sleeping Habits	[ ] YES [ ] NO _____
School Experience	[ ] YES [ ] NO _____
Bathroom/Toilet Habits	[ ] YES [ ] NO _____
Discipline	[ ] YES [ ] NO _____
Other (explain)	[ ] YES [ ] NO _____

IMMUNIZATIONS Up to date? [ ] YES [ ] NO