

CHILD HISTORY QUESTIONNAIRE

Child's Name: _____

Date of Birth: _____

Parent/Legal Guardian's Name: _____

Home Address:

Home: _____

Cell: _____

Work: _____

Prenatal History:

Birth Weight _____ Height _____ Duration of Pregnancy _____

Type of Delivery _____

Complications at birth: _____

Please list any injuries, infections, illnesses, hospitalizations, surgeries or other medical procedures your child has had and the ages these occurred:

Does your child have any allergies, seizures or other medical precautions?

Current Medications:

Developmental Milestones: At what age did your child do the following?

Sit unsupported _____

Sit supported _____

Pull to stand _____

Crawl _____

Cruise _____

Walk _____

Run _____

Begin solid foods _____

Finger feed self _____

Use spoon _____ Use fork _____

Drink from uncovered cup _____

Use straw _____

How does your child spend their day? (Preschool, daycare, home)

Please describe your concerns for this child

What does your child like/dislike?

Is your child presently receiving any therapies and if so, what is the frequency and where is it provided?
