



Medical History Intake Form

Child's Name _____ Date _____

Date of Birth _____ Age _____ Gender _____

Address _____

Home Phone _____ Cell Phone _____ Email _____

Please list in your own words the **worrisome behaviors** that have prompted you to seek this evaluation

Please list in your own words the **developmental concerns** that have prompted you to seek this evaluation

FAMILY MEDICAL HISTORY

Does anyone in your family have the following problems?

NO	YES	Who? (please do not include the child being evaluated)
		Obesity
		Diabetes
		Heart problems/strokes
		Arthritis
		High Cholesterol
		Kidney or bladder problems
		Asthma/allergies
		Stomach or bowel problems
		Cancer (type?)
		Speech and language delay
		Violent behavior
		Hearing problems
		Depression
		Migraines or significant headaches
		Seizures/convulsions
		Learning difficulties
		ADHD/hyperactivity
		Autism
		Aggressive behavior
		Mental retardation
		Substance abuse problem with alcohol or drugs
		Neurological problems
		Spina Bifida
		Cerebral Palsy
		other

Please list anything else that runs in your family that you think might be of importance to us. _____

How would you describe your child's temperament or personality (check all that apply).

- | | | |
|--|--|---|
| <input type="checkbox"/> Easy going | <input type="checkbox"/> Easily Upset | <input type="checkbox"/> Happy |
| <input type="checkbox"/> Reacts Negatively | <input type="checkbox"/> Defiant | <input type="checkbox"/> Angry |
| <input type="checkbox"/> Flexible | <input type="checkbox"/> Inactive | <input type="checkbox"/> Difficult to comfort |
| <input type="checkbox"/> Feisty | <input type="checkbox"/> Needs Routine | |
| <input type="checkbox"/> Cautious | <input type="checkbox"/> Lazy | |
| <input type="checkbox"/> Fussy | <input type="checkbox"/> Oppositional | |
| <input type="checkbox"/> High Intensity | <input type="checkbox"/> Easily distractible | |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Adapts well to new situations | |
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Does not adapt well | |
| <input type="checkbox"/> Irregular | <input type="checkbox"/> Active | |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Moody | |