I. PARENT CONCERNS

1. Please describe your main concerns about your child:

2. When did you first worry about these problems?

3. Have you talked to your pediatrician about your concerns? When?

4. What have you tried to do about these problems in the past?

5. What are your child's special qualities and strengths?

II. CHILD’S BIRTH HISTORY

Is this child adopted? __ No __ Yes At age ___ months/years from (country)______________________

Pregnancy, Labor and Delivery	**YES**	**NO**	**COMMENTS**
1. Age of mother when child was born: ____ years			
2. Is this child a twin or triplet?			
3. Any problems with other pregnancies? Miscarriages?			
4. Use in vitro fertilization or other method of conception?			
5. Were there any problems during this pregnancy?			
6. Any medications prescribed? Why?			
7. Gestational diabetes (sugar in urine)?			
8. Any problem with blood pressure or toxemia?			
9. Any problems with infections (including herpes)?			
10. Smoking during pregnancy? How many packs per day?			
11. Drank alcohol (beer, wine, etc) during pregnancy?			
12. Any street drugs (marijuana, cocaine, etc.) used?			
13. Any problems during labor or delivery?			
14. Cesarean delivery? Why?			
15. Baby was born at _____ weeks			

Newborn History	YES	NO	COMMENTS
1. Birth weight? _____ lbs. _____oz.			
2. Were there any problems at birth or as a newborn?			
3. Were any birth defects or birth injuries noted?			
4. Put in Special Care or Intensive Care Nursery? ____days			

5. Have jaundice and need phototherapy?			
6. Very jittery or lethargic as a newborn?			
7. Baby had to stay extra days in the hospital? ____days			

III. INFANT TEMPERAMENT

Please describe your child as an infant or toddler:

____

____

More infant temperament…	YES	NO	COMMENTS
1. Problems with feeding in infancy?			
2. Severe or prolonged colic or excessive crying?			
3. Difficult temperament (irritable or demanding)?			
4. Excessively wiggly or active?			
5. Easily over-stimulated?			
6. Passive, shy or withdrawn?			
7. Didn't like to be held or cuddled?			
8. Trouble keeping a babysitter?			

IV. CHILD'S MEDICAL HISTORY

	YES	NO	Please comment below if "YES"
1. Problems with vision? Crossed eyes? Wears glasses?			
2. Problems with hearing?			
3. Serious or chronic health problem (such as diabetes)?			
4. Birth defect or birthmarks?			
5. Hospitalizations or surgery?			
6. Serious infections or illness (e.g. meningitis)?			

Rapha® physical therapy

7. Serious injury, burn or broken bones?			
8. Head injury or lost consciousness?			
9. Frequent accidents or multiple minor injuries?			
10. Poisoning or exposure to toxic chemicals (e.g. lead)?			
11. History or suspicion of physical or sexual abuse?			
12. Fainting or dizziness?			
13. Seizures, convulsions or febrile seizures? staring spells?			
14. Staring episodes or spells?			
15. Motor tics (repeated blinking, squinting, head tossing)?			
16. Vocal tics (repeated grunting, throat clearing noises)?			
17. Compulsive mannerisms (hand washing, picking, counting)?			
18. Multiple ear infections? Chronic antibiotics or ear tubes?			
19. Serious nose, mouth or throat problems?			
20. Thyroid disorders or other hormone problems?			
21. Breathing or lung problems (pneumonia, asthma)?			
22. Too fast heart beat (palpitations) or chest pains?			
23. Frequent aches and pains?			
24. Problems with vomiting, diarrhea or constipation?			
25. Problems with kidneys, bladder or urine?			
26. Blood problems or anemia (iron deficiency or low blood count)?			
27. Difficulties with eating, diet or appetite?			

28. Small for age or underweight?			
29. Over eats or overweight?			
30. Problems with restless sleep or snoring?			
31. Allergies to medications? Specify.			
32. Other allergies? Specify.			
33. Any vitamin supplements? Specify.			
34. Any herbal medicines or other nutritional supplements?			
35. Any non-medical treatments (special diet, chiropractic, acupuncture, etc.)?			
36. Unusual reaction to immunization? 36. Are immunizations up to date?			

V. CHILD'S SOCIAL DEVELOPMENT

1. Describe your child's temperament or personality.____

____

2. How does your child get along with adult members of the family?

____

____

3. How does your child get along with adults outside the family?

____

____

4. How does your child get along with siblings?

____

____

5. How does your child get along with playmates/peers?

____

Please think about your child's behavior over the past 6 months. Circle the answer that best describes how often you have noticed each kind of behavior.

1. **Is your child interested in playing with other children?**

Very Often Often Sometimes Rarely Never

2. **When you say a word or wave your hand, does your child try to copy you?**

Very Often Often Sometimes Rarely Never

3. **Does your child look at you when you call his or her name?**

Very Often Often Sometimes Rarely Never

4. **Does your child look if you point to something across the room?**

Very Often Often Sometimes Rarely Never

5. **Does your child bring things to you to show them to you?**

Many times a day A few times a day A few times a week Less than once a week Never

6. **How does your child <u>usually</u> show you something he or she wants?**

Says a word for it Points to it with one finger Reaches for it Pulls me over or puts my hand on it Grunts, cries, or screams

7. **What are your child's favorite play activities?**

Playing with dolls or stuffed animals Reading books with you Climbing, running, and being active Lining up toys or other things Watching things go round and round like fans or wheels

Area of Development	**My Child is Doing OK**	**I'm a little worried**	**I'm somewhat worried**	**I'm very worried**
1. General Development				
2. Speech and language skills				
3. Motor skills				
4. Feeding/Eating				
5. Sleeping				
6. Cognitive/ thinking skills				

7. Social skills				

VI. CHILD'S DEVELOPMENTAL HISTORY

Did your child seem to develop normally but then lose developmental skills? NO YES

If yes, describe: ____

The following questions are about your child's communication skills. Please answer if/when your child could…	**Not yet**	**Yes**	**At What Age?**
1. Understand and respond to name?			
2. Understand simple commands?			
3. String sounds together (uh oh, gaga, bada, dada, mama)?			
4. Pretend talk (with inflections that sound like conversation)?			
5. Say first word (that he/she then used consistently)?			
6. Put two words together (want cookie, Mommy work, Dad car)?			
7. Use pronouns to refer to self and others?			
8. Strangers understand most of what he/she says?			
9. Attends to a short story and answers simple questions about it?			
10. Speak in fairly complex sentences?			
The following questions are about your child's motor skills. Please answer if/when your child could…	**Not yet**	**Yes**	**At What Age?**
1. Sit up without being held or propped?			
2. Crawl or scoot?			
3. Walk alone?			
4. Jump off the floor with both feet? 5. Throw a ball?			

	Not yet	Yes	At What Age?
6. Catch a medium-sized ball?			
7. Pick up small objects with thumb and one finger?			
8. Unwrap loosely wrapped small objects?			
9. String half-inch-sized beads on a string?			
10. Copies letters?			
The following questions are about your child's self-help skills. Please answer if/when your child could…	**Not yet**	**Yes**	**At What Age?**
1. Feed self using spoon in scooping motion?			
2. Feed self using fork to prick food?			
3. Help you in dressing/undressing him/herself?			
4. Unzip a zipper?			
5. Unbutton front buttons?			
6. Toilet-trained in day?			
7. Toilet-trained at night?			
8. Wash/dry hands by himself/herself?			
The following questions are about your child's pre-academic skills. Please answer if/when your child could…	**Not yet**	**Yes**	**At What Age?**
1. Identify basic colors consistently?			
2. Identify shapes consistently?			
3. Identify several letters consistently?			
4. Count 2-3 objects correctly?			
5. Can state the use of objects (e.g. car, fork)?			

VII. CHILD'S BEHAVIORAL HISTORY

1.How do you usually handle misbehavior?

2. How does your child respond to being told “no” or being corrected for misbehaving?

3. How does your child respond to praise, rewards or positive reinforcement?

4. Do you and your partner agree on how to handle misbehavior?

▫Usually Agree ▫Sometimes Agree ▫Often Disagree

Please answer how often the below items describe your child’s behavior.

The following questions are about your child’s sensory experiences:

	NEVER	SOMETIMES	OFTEN	VERY OFTEN	OFFICE NOTES
1. Unusually sensitive hearing or sense of smell					
2. Bothered by how things feel (clothes, being hugged)					
3. Over- or under-sensitive to pain					
4. Easily over-stimulated; winds up or shuts down					
5. Unusual or limited diet					
6. Hurts herself/himself on purpose					
7. Eats things that are not food (“pica”)					
8. Unaware of dangerous situations					

The following questions are about repetitive behaviors or habits:

	NEVER	SOMETIMES	OFTEN	VERY OFTEN	OFFICE NOTES
1. Echoes words or phrases					
2. Hard to get child's attention					
3. Prefers to be alone; ignores others					
4. Does things just to get you to laugh					
5. Handles change poorly; insists on same routines					
6. Excessive or public masturbation					
7. Excessive thumb-sucking or nail-biting					
8. Other habits (e.g. pulls out hair or lashes)					

The following questions are about your child's ability to handle anxiety.

	NEVER	SOMETIMES	OFTEN	VERY OFTEN	OFFICE NOTES
1. Is fearful, anxious or worried					
2. Doesn't try new things for fear of making mistakes					
3. Is sad, unhappy or depressed					
4. Has unusually hard time being away from parents					
5. Refuses to speak except to family members					
6. Resists going to school					

	NEVE R	SOMETIM ES	OFTE N	VERY OFTE N	TOO YOUN G	OFFICE NOTES
1. Has temper tantrums						
2. Argues with adults						
3. Defies or refuses to do as asked						
4. Deliberately annoys others						
5. Is angry or resentful						
6. Tries to get even or takes out anger on others						
7. Blames others for misbehavior						
8. Bullies, threatens or intimidates others						
9. Does serious lying or cheating						
10. Starts physical fights						
11. Is cruel to animals						

The following questions are about your child's ability to follow rules and routines.

Please answer how often your child…

Please review the following items and indicate if they describe your child's behavior.

Behavioral Overview	YES	N O	Office Notes
1. Does your child enjoy being swung, bounced on your knee, etc?			
2. Does your child take an interest in other children?			
3. Does you child like climbing on things, such as up stairs?			
4. Does your child enjoy playing peek-a-boo/hide-and-seek?			
5. Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things?			

6. Does your child ever use his/her index finger to point, to ask for something?			
7. Does your child ever use his/her index finger to point, to indicate interest in something?			
8. Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling, or dropping them?			
9. Does your child ever bring objects over to you (parent) to show you something?			
10. Does your child look you in the eye for more than a second or two?			
11. Does your child ever seem oversensitive to noise (e.g. plugging ears)?			
12. Does your child smile in response to your face or your smile?			
13. Does your child imitate you? (e.g. you make a face – will your child imitate it?)			
14. Does your child respond to his/her name when you call?			
15. If you point at a toy across the room, does your child look at it?			
16. Does your child walk?			
17. Does your child look at things that you are looking at?			
18. Does your child make unusual finger movements near his/her face?			
19. Does your child try to attract your attention to his/her own activity?			
20. Have you ever wondered if your child is deaf?			
21. Does your child understand what people say?			
22. Does your child sometimes stare at nothing or wander with no purpose?			
23. Does your child look at your face to check your reaction when faced with something unfamiliar?			

VIII. FAMILY COMPOSITION

Child lives with: __ Biological Mother __ Biological Father __ Stepmother __ Stepfather __Partner

__ Adoptive Mother __ Adoptive Father __ Foster Mother __ Foster Father __Guardian

__ Other Adult (e.g. grandparent or boyfriend) Specify: ______________________________

Biological mother's name: ____

Age: ____ **Occupation:** ___________________________ **Highest level of school completed:** ___________

Biological father's name: ____

Age: ____ **Occupation:** _________________________ **Highest level of school completed:** ____________

Adoptive/step/other mother name: __________________________ **Occupation:** ___________________

Highest level of school completed: ____

Adoptive/step/other father name: ________________________ **Occupation:** ______________________

Highest level of school completed ____

Additional adults: ____

____

Parents' Marital Status: __ Married __ Never married __ Separated / Divorced __ Widowed

How do the parents get along with each other? ____

If separated/divorced, how long? ____

Contact with non-custodial parent or custody arrangements: ___________________________________

____

Child care arrangements:____

Any special circumstances in the family situation?

What does the family enjoy doing together?

Child's siblings or other children living IN the home:	Full, half, adoptive, step, etc.	Age

Child's siblings NOT living in the home:	Full, half, adoptive, step, etc.	Age

IX. FAMILY HISTORY

Biological Family Medical and Psychiatric History (if adopted indicate information on any known biological relatives and indicate information on adoptive family members on lines below)

Any one in this child's biological family have:	Yes	No	**How is this person related to child:**
Attention problems/ADHD			
Behavior problems as child or teen			
Speech or language problems			
School problems			
Reading problems or dyslexia			
Seizures or neurological problem			
Unusual drug reaction			
Mental retardation			
Birth defect or genetic disorder			
Tics/Tourette's Syndrome			
Autism spectrum disorder or PDD			
Thyroid problems			
Heart problems before age 50			
Physical or sexual abuse			
Depression			
Bipolar / manic depression			
Social problems/shyness			
Anxiety or panic attacks			
Obsessive-compulsive disorder			
Schizophrenia			
Alcohol problems			

Drug problems			
Trouble with the law			

Other problems that run in biological family:____

____

Other problems that run in step-, adoptive or foster family: _____________________________________

____

Any difficult circumstances in either parent's childhood (e.g. abuse, alcoholic parents)?

____
____
____

Does anyone in the family have problems similar to this child's? If so who? ______________________

X. CHILD'S HOME LIFE

	Stressful Life Experiences	Yes	No	Office Notes
1.	Child had a very upsetting experience (e.g. witnessed violence, physical abuse, sexual abuse, severe accident)?			
2.	Moved? Number of moves: ______			
3.	Out of home placement (foster care, residential center)			
4.	Family problems that may be bothering child?			
5.	Divorce/separations/remarriage?			
6.	Frequent arguments and/or physical abuse in home?			
7.	Serious physical illness in parent, caregiver or sibling?			
8.	Serious money or housing problems?			
9.	Concerns about safety in neighborhood?			
10.	Are there guns in the house?			

How much time per day does your child usually spend watching TV?
____

How much time per day does your child usually spend on computer/video games?
____

XI. CHILD'S SERVICES HISTORY

Placement, Programs and Services (now or in the past)	**# days/ week**	**# min/ session**	**Comments**
Early Intervention Program (0 to 3 years)? Name:_________________			
Developmental specialist:			
Speech/Language Therapy			
Occupational Therapy?			
Physical Therapy?			
Play Group?			
Behavior Therapy (also known as ABA or Floortime)? Provider:_______________			
Day Care: Name: __________________			
Pre-school: Name:________________ School district:_______________ Teacher: _______________ Phone: ______________ # of teachers/aides:__________ # students:_________ Does your child have his/her own 1:1 aide? __________			

Ever suspended from school or daycare?
____

Ever received any other special education or therapeutic services? ____ If yes, please specify:
____

____

How satisfied are you with your child's current school placement and services?

Very Satisfied Somewhat satisfied Not satisfied

Comments:

____
____
____

XII. CHILD´S PREVIOUS EVALUATIONS AND TREATMENTS

Please indicate if your child has had any previous evaluations and attach any reports.

Has your child had other evaluations? (including school, psychologist, neurologist or other specialist doctors)

Year	Professional's Name	Type of Testing

MEDICAL TESTS including EEG, MRI, Chromosome test, etc.?

Year	Type of Testing	Results

Has your child received private counseling?

Therapist	Date Started	Date Stopped

Has your child taken medication for attention, behavior or emotional problems? _____Yes _____ No

Medication (e.g. Ritalin Sustained Release)	Dosage (e.g. 20 mg 3x day)	Month/year Started	Month/year Stopped	Effects or Adverse Effects

XIII. OTHER INFORMATION

Please add any other information you think may help us understand your child.

____
____
____
____
____

Thank you.