Patient

Last Name_____ First Name _____ Date_____

Nick Name _____ Age _____ DOB _____ (Circle) Male Female

Address_____ City_____ State_____ Zip Code_____

Phone # (H) _____ (C) _____

Email Address _____

School _____ Activities_____

Who referred you to our office? _____

Please give a brief description of the reason you're here.

_____

_____

Where did you hear about us? _____

Responsible Party

Last Name _____ First Name_____ Home Phone_____

Address (if different from above) _____

Occupation_____ Employer _____ Work Phone_____

(Circle) Single Married Divorced Separated O.k. to contact you at work? Y N

Spouse _____ Home Phone_____

Address (if different from above) _____

Address (if different from above) _____

Occupation _____ Employer _____ Work Phone_____

Did the mother have any illnesses or complications during pregnancy and birth? ( ) Yes ( ) No
If yes, explain: _____
_____

Did the mother take any prescription or non-prescription drugs (including alcohol) during pregnancy?
( ) Yes ( ) No If yes, what kind, how often, and how much?_____
_____

Was the pregnancy full term? ( ) Yes ( ) No If premature, how long was the pregnancy? _____

How much did the baby weigh at birth? _____

Did your newborn have any of the following difficulties? ( ) Fever ( ) Allergies ( ) Convulsions
( ) Excessive vomiting ( ) Bleeding ( ) Brain injury ( ) Feeding problems ( ) Breathing problems

Explain any medical difficulties of your newborn _____
_____
_____

Please give approximate ages at which the following occurred:
Motor Development
Sat alone _____ Crawled _____
Stood alone _____ Walked alone _____
Fed self _____ Dressed self _____
Toilet trained _____

Speech/Language Development
Babbled_____ Spoke first words_____
Put words together_____

Has the child's development appeared to be normal? ( ) Yes ( ) No If no, explain_____
_____

III. MEDICAL INFORMATION

Health Care Providers

Dentist:	**Ortho:**
Name:_____	Name:_____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone: _____	Phone: _____
MD:	**Other:**
Name:_____	Name:_____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone: _____	Phone: _____

Has the student ever had high fever, serious illnesses, accidents or head injuries? ( ) Yes ( ) No
If yes, describe and tell at what age it occurred_____
_____
_____

Did the condition described above require treatment in hospital? ( ) Yes ( ) No
If yes, which hospital and for how long?_____
_____

Does the student have frequent illnesses or health problems? ( ) Yes ( ) No
If yes, explain_____
_____
_____

Does the student take a prescription medication? ( ) Yes ( ) No
If yes, list medication(s), dosage, and purpose_____
_____
_____

Does the student have vision or hearing problems? ( ) Yes ( ) No
If yes, explain_____
_____

Has the student experienced any events that could affect school performance (death in the family, divorce)?
_____
_____
_____

Does the client have a tendency towards:	**Colds**	**Sore Throats**	**Ear Infections**	**Headaches**

How Often? _____

	Yes	**No**
Have the Tonsils and/or Adenoids been removed? --- If so, at what age? _____		
Does the client have jaw popping and/or pain?		
Does the client have frequent headaches?		
Has there ever been an injury to the face or mouth?		
As the client ever sucked his/her thumb or fingers? If so, until what age?		
Does the client have any speech problems?		
Does the client breathe through his/her mouth while awake?		
Does the client breathe through his/her mouth while asleep?		
Does the client clench or grind his/her teeth at night?		

Please list any drugs or medications currently being taken: _____

_____

Other pertinent Health information? _____

V. EDUCATIONAL BACKGROUND
Has this student been evaluated for special education previously? _____ If so, explain outcome:
_____
_____
_____

Did this student attend kindergarten? _____Full Day _____Half Day _____ Didn't attend

How would you describe the student's ability to learn? ( ) Average ( ) Above average ( ) Below Average

How would you describe the student's effort to learn? ( ) Average ( ) Great deal of effort ( ) Little effort

Has the student ever missed over 10 days of school during the same year? ( ) Yes ( ) No If yes, explain

_____

_____

Has the student repeated a grade? _____ If so, which? _____

READING (decoding)

____ Above average ___Average ____Below Average

READING (Comprehension)

____ Above average ___Average ____Below Average

WRITTEN LANGUAGE

____ Above average ___Average ____Below Average

Describe any concerns the parent has about the student's learning or school performance._____

_____

_____

_____

Strengths/Interests/learning preferences (Please write at least one for each of these areas)

_____

_____

Motor Skills: Gross Motor (i.e. P.E. skills, running, jumping etc.)

____ Above average ___Average ____Below Average

Fine Motor (i.e. writing, cutting, manipulating small objects)

____ Above average ___Average ____Below Average

Comments:

_____

_____

Social/Emotional Development

- ❑ Gets along well with others
- ❑ Adequate social skills
- ❑ Good peer relations
- ❑ Adequate peer relations
- ❑ Social skills need improvement
- ❑ Difficulty maintaining friendships