EBS CARES: Medical History Form

Child's Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ years _____ months Sex: ☐ Male ☐ Female

Person Completing Form: _____ Relationship to Child: _____

Race/Ethnicity (check all that apply):

☐ Caucasian ☐ Hispanic ☐ Native Alaskan/American Indian ☐ Asian
☐ African American ☐ Non-Hispanic ☐ Native Hawaiian/Pacific Islander

School District: _____

Physician Name: _____ Phone Number: _____

Physician Address: _____

Has your child been diagnosed with any medical or developmental conditions? ☑ Yes ☐ No

If yes, please complete:

Condition:	**Date of Diagnosis:**	**Given by whom:**

Does your child receive any of the following services?

Service:		**When did it start?**	**How often (per week/month)?**	**Who provides services?**
Occupational Therapy	☐ Yes ☐ No			
Physical Therapy	☐ Yes ☐ No			
Speech Therapy	☐ Yes ☐ No			
Behavioral Therapy	☐ Yes ☐ No			
Feeding Therapy	☐ Yes ☐ No			
Early Intervention/IU	☐ Yes ☐ No			
Specialized Instruction/ Developmental Therapies	☐ Yes ☐ No			

Prenatal History

Is child: ☐ adopted ☐ in foster care If so, from what age? _____ ☐ N/A

How old was mother when she became pregnant? _____

Did the mother have any health problems during pregnancy? ☐ Yes ☐ No

- If yes, explain:_____

Did the mother use any prescription or non-prescription drugs during pregnancy? ☐ Yes ☐ No

- If yes, explain:_____

Labor and Delivery

Where was the child born? _____

Was the delivery: ☐ Vaginal ☐ C-section ☐ Breech ☐ Don't know

Were there any complications? ☐ Yes ☐ No

- If yes, explain: _____

Was the baby full term? ☐ Yes ☐ No If no: ☐ Early ☐ Late by ____ weeks

Baby's birth weight: _____lbs, _____oz Baby's length at birth: _____ inches

Were there any of the following problems in the nursery (please explain if checked)?

- ☐ Was in NICU _____
- ☐ Breathing problems _____
- ☐ Low oxygen _____
- ☐ Infection _____
- ☐ Needed ventilator _____
- ☐ Feeding/sucking problems _____
- ☐ Tube feedings _____
- ☐ Jaundice _____
- ☐ Needed light therapy _____
- ☐ Apnea _____
- ☐ GER (reflux) _____
- ☐ Other: _____

Review of Systems

	Normal	Abnormal	Comments
Head, eyes, ears, nose, throat	☐	☐	_____
Vision Screening (date:_____)	☐	☐	_____
Hearing screening (date:_____)	☐	☐	_____
Heart	☐	☐	_____
Lungs	☐	☐	_____
Stomach/Intestinal/Constipation	☐	☐	_____
Skin	☐	☐	_____
Sleeping/Snoring	☐	☐	_____
Muscles/joints/bones	☐	☐	_____
Neurological (nervous system)	☐	☐	_____
Nutrition/Diet	☐	☐	_____

Please list medications your child is currently taking (including vitamin supplements): ☐ None

Medication	Dose	Frequency

Has your child ever been hospitalized or required surgery? ☐ Yes ☐ No
If yes, please complete:

Date	Reason

Does your child have any allergies? ☐ Yes ☐ No

- If yes, what are they? _____

Behavioral History

Activity level of child:

☐ Normal ☐ High ☐ Low

Emotionality:

☐ Happy ☐ Angry ☐ Moody ☐ Depressed ☐ Other: _____

Sociability with other children:

☐ Ignores children ☐ Observes them ☐ Parallel play ☐ Initiates play

☐ Joins play ☐ Intrudes on play ☐ Prefers adult interaction

What does your child like to do for play? _____

Does your child have difficulty with any of the following behaviors (currently or past—please explain):

Behavior	How does child display this behavior (ie: hits, scratches, runs away)	Frequency (How often does this happen-# of times daily, weekly, month)	Duration (when did behavior begin/how long does it last when occurs)
Aggression			
Hyperactivity			
Impulsivity			
Mouthing objects			
Non-compliance/ not obeying			
Obsessive behavior			
Self-injury			
Self-stimulation			
Sleep difficulties			
Tantrums			

Family/Social History

	Name	Age	Occupation	Employed?
Child's Father				☐ Yes ☐ No
Child's Mother				☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Partner

Please list all of mother's pregnancies and the outcome of each:

Year	Outcome	Name	Sex	Present Age	Developmental concerns?	If yes, what?
	☐ Living ☐ Miscarriage		☐ Male ☐ Female		☐ Yes ☐ No	
	☐ Living ☐ Miscarriage		☐ Male ☐ Female		☐ Yes ☐ No	
	☐ Living ☐ Miscarriage		☐ Male ☐ Female		☐ Yes ☐ No	

Is there a history of developmental concerns or medical concerns in the mother? ☐ Yes ☐ No

- If Yes, please explain: _____

Is there a history of developmental concerns or medical concerns in the father? ☐ Yes ☐ No

- If Yes, please explain: _____

Who lives at home with the child? _____

Is your child enrolled in any type of childcare facility, preschool program, Early Intervention or other developmental therapy program? ☐ Yes ☐ No

Name of School/Facility:_____ When did they start?: _____

Hours enrolled per week: _____

Has your child ever had any prior evaluations? ☐ Yes ☐ No

- If Yes, describe type of evaluation and where/who performed:

  _____

Does your child have an IFSP or IEP? ☐ Yes ☐ No

If Yes, indicate which type of plan and a summary of services received: ☐ IFSP ☐ IEP

- Comments: _____

Would you be willing to share the child's IFSP/IEP with EBS? ☐ Yes ☐ No

What do you feel are your child's strengths? _____

What are your concerns about your child? _____