**Pediatric Health History Form**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Gender: *M F*

Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnic Background: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of parent(s)/guardian(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(home)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(work)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(other)

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is the child adopted? *Yes No*

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are parents: *Unmarried Married Remarried Widowed Separated Divorced* Who does the child live with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s primary care physician / pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can we contact this doctor? *Yes No*

Emergency Contact (Name & Phone Number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the health concerns of the child in order of importance:

|  |  |
| --- | --- |
| **1.** | **4.** |
| **2.** | **5.** |
| **3.** | **6.** |

**Medical History**

Please describe any serious conditions, hospitalizations, operations, illnesses or injuries with their dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list all current medications the child is taking (i.e. prescription, over-the-counter, etc):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all vitamins, herbs, homeopathics or other supplements the child is taking: \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please list any medication your child has taken for an extended period of time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever taken antibiotics? *Y N*  If yes, for what condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any allergies (environmental, medication, seasonal, etc.)? Describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate if the child has recently been tested for the following:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Condition** | **Yes / No** | **When?** | **Condition** | **Yes / No** | **When?** |
| Hearing |  |  | Vision |  |  |
| Yearly physical |  |  | Dental |  |  |
| Speech |  |  | Blood Tests |  |  |

Please circle if your child has experience any of the following conditions currently (C) or in the past (P) – you may circle both if applicable:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Strep Throat** |  | **Asthma** |  | **Hives/Rashes** |  |
| **Chicken Pox** |  | **Bronchitis** |  | **Eczema** |  |
| **Measles** |  | **Allergies** |  | **Herpes (Oral)** |  |
| **Rubella** |  | **Itchy Eyes** |  | **Bruises Easily** |  |
| **Mononucleosis** |  | **Chronic Colds** |  | **Bad Breath** |  |
| **Mumps** |  | **Sinus Troubles** |  | **Fainting** |  |
| **Roseola** |  | **Ear Infections** |  | **Seizures** |  |
| **Whooping Cough** |  | **Recurring Fevers** |  | **Headaches** |  |
| **Influenza** |  | **Constipation** |  | **Temper Tantrums** |  |
| **Scarlet Fever** |  | **Diarrhea** |  | **Bed Wetting** |  |
| **Impetigo** |  | **Digestive Problems** |  | **Nail Biting** |  |
| **Pneumonia** |  | **Colic** |  | **Depression**  **Anxiety** |  |

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Any Medical Conditions?** | **Are they still living?** | **If not, cause of death?** | **Age** |
| **Mother** |  |  |  |  |
| **Maternal Grandmother** |  |  |  |  |
| **Maternal Grandfather** |  |  |  |  |
| **Father** |  |  |  |  |
| **Paternal Grandmother** |  |  |  |  |
| **Paternal Grandfather** |  |  |  |  |
| **Siblings:** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Immunizations**

Has your child received regular vaccinations according to the standard Pediatric schedule? *Y N*  If no, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If known, please indicated which of the following vaccinations your child has had:

|  |  |  |
| --- | --- | --- |
| DPT (diphtheria, pertussis, tetan  HiB (Haemophilus, influenza B)  Hepatitis A | Tetanus booster  Polio  Hepatitis B  MMR (measles, mumps, rubella) | Chicken pox  Flu shot  Meningitis  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Is the child current with their vaccination schedule? *Yes No*

Has your child had any adverse reactions to a vaccination? *Yes No*

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prenatal History**

Was this a planned pregnancy?  *Yes No*

Were there any fertility issues? Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the child conceived using fertility treatments? *Yes No* If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the health of the parents at conception?

*Mother:* Excellent Good Fair Poor Unknown

*Father:*  Excellent Good Fair Poor Unknown

What was the mother’s health during pregnancy? Excellent Good Fair Poor Unknown

What was the mother’s diet during pregnancy? Excellent Good Fair Poor Unknown

Did the mother experience any of the following during the pregnancy (check applicable):

Emotional Stress  Nausea  Vomiting  High Blood Pressure  Diabetes

Placenta Previa  Toxemia  Bleeding  Thyroid Problems

Ultrasounds  Physical Trauma  Exposure to cigarette smoke  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any particular food cravings during the pregnancy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the mother’s age at the child’s birth? \_\_\_\_\_\_\_\_ Father’s age at birth? \_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any genetic concerns with regards to the parents or the child? Describe. \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the mother receive any prenatal medical care? Yes No Unkown

Did the mother work during the pregnancy? Yes No If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the mother use any of the following during the pregnancy?

Tobacco  Alcohol  Caffeine  Recreational Drugs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Prescription Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Over the counter Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birth History**

Term Length:  Premature: \_\_\_\_\_\_\_wks  Early: \_\_\_\_\_\_\_\_wks  Full  Late: \_\_\_\_wks

Birth weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Length \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APGAR score: 1min \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5min \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Delivery by:  Vaginal Birth  Cesarean, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check if any of the following interventions apply to the birth:

Forceps  Vacuum extractions  External fetal monitor  Epidural  Pitocin  Induction of labour  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any complications during/after delivery? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If male, has the child been circumcised? Yes No

Did the child experience any of the following at or shortly after birth?

Jaundice  Rashes  Seizures  Birth injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth defects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the child receive any regular medical care during their first year? Yes No

By whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate any medical problems during baby’s newborn/infancy period: \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutrition & Diet**

Was your child breastfed? Yes No If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If formula was introduced, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When were solid foods introduced? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which foods were introduced first? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any reactions? Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any food allergies or intolerances: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)? \_\_\_\_\_\_\_\_\_

Does your child have any food aversions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child a “picky” eater? Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any unusual feeding/dietary issues or habits? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Milk intake now:

Cow milk ( Non-fat  1%  2%  Whole)  Soy milk  Rice milk  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does your child:

Drink soda pop? More than once a day Once a day Sometimes Never

Have caffeine? More than once a day Once a day Sometimes Never

Eat chocolate? More than once a day Once a day Sometimes Never

Eat candy? More than once a day Once a day Sometimes Never

Eat take-out/fast food? More than once a day Once a day Sometimes Never

Please describe a typical day’s diet:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Breakfast** | **Lunch** | **Dinner** | **Snacks** | **Beverages (incl. amounts)** |
|  |  |  |  |  |

**Sleep**

Does the child sleep through the night? Yes No Occasionally

Hours per night \_\_\_\_\_\_\_\_\_\_ Naps (number & length) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child feel sleepy during the day? Yes No At what time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any sleeping problems? Yes No

Does the child have night terrors/nightmares? Yes No Occasionally

How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child have any recurring themes in their dreams? Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Development**

Child’s weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age did your child:

Sit alone? \_\_\_\_\_\_\_ Crawl? \_\_\_\_\_\_\_\_\_ Walk alone? \_\_\_\_\_\_\_\_\_ Say words? \_\_\_\_\_\_\_\_ Toilet train? \_\_\_\_\_\_\_\_ First tooth eruption? \_\_\_\_\_\_\_\_\_

**Lifestyle/Environment**

Is the child presently in:  School  Daycare  Homecare  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which best describes the child’s home:  Rural  Sub-urban  Urban

What are your child’s favourite activities/interests? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child exposed to cigarette smoke? Yes No If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have pets:  No  Yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you know of any environmental toxins or hazards (chemicals, fumes, dust, etc) your child is regularly exposed to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does your child:

|  |  |
| --- | --- |
| **Activity** | **How often?** |
| Watch TV/Videos |  |
| Play videogames |  |
| Work on computer |  |
| Play sports |  |
| Exercise |  |
| Read (or is read to) |  |
| Outdoor activities |  |
| Other: Click here to enter text. |  |

Please describe your child’s temperament: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any fears/anxieties/worries your child has: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your child’s behaviour and performance at school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If over 4 years old, does your child have a “best” friend? Yes No

Are there any concerns about relationships with:

Teachers:  No  Yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Peers:  No  Yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings:  No  Yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents:  No  Yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the child known to have or suspected of having any learning disability/difficulty? Describe: \_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If applicable, how many nights per week does the child have homework? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours per night does the child usually spend on homework? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe the emotional climate of the child’s home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any other relevant information you would like to discuss that has not been covered? \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_