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FAMILY AND MEDICAL HISTORY FORM

PART 1 - GENERAL INFORMATION

CHILD'S FULL NAME: ______________________________ DATE OF BIRTH: ______________________

HOME ADDRESS: ____

BEST CONTACT PHONE: ________________________ CONTACT NAME: ___________________

SECONDARY CONTACT PHONE: ____________________ CONTACT NAME: _____________________

EMAIL ADDRESS: ____

PHYSICIAN'S NAME: ________________________________ **PHONE #:** _________________________

COMPOSITION OF FAMILY IN WHICH CHILD CURRENTLY RESIDES (Primary Caregivers)

FATHER'S NAME: __________________________________ DATE OF BIRTH: ______________________

SOCIAL SECURITY #: ______________________________ OCCUPATION: ________________________

HIGHEST EDUCATIONAL LEVEL: ______________________ RELIGION: ____________________________

RELATIONSHIP TO CHILD (please circle one): Biological Adoptive Step Foster Other

MOTHER'S NAME: _________________________________ DATE OF BIRTH: ______________________

SOCIAL SECURITY #: ______________________________ OCCUPATION: ________________________

HIGHEST EDUCATIONAL LEVEL: ______________________ RELIGION: ____________________________

RELATIONSHIP TO CHILD (please circle one): Biological Adoptive Step Foster Other

IF BOTH PRIMARY CAREGIVERS WORK, WHO CARES FOR THE CHILD?

ADDRESS: ____

PHONE#: _______________________ WHEN IS CHILD IN THIS CHILDCARE? _____________________

EMERGENCY CONTACTS (please provide two additional people, different from the parent/guardian listed above, who would automatically be the first person we contact)

First Contact's Name: ______________________________________ Relationship: __________________________

Home Phone: _____ - ______ - ______ Work/Cell Phone: _____ -______ - ______ ext ______

Second Contact's Name: ___________________________________ Relationship: __________________________

Home Phone: _____ - ______ - _______ Work/Cell Phone: _____ -______ - ______ ext ______

OTHER PERSONS LIVING IN THIS CHILD'S HOUSEHOLD:

NAME SEX AGE RELATIONSHIP TO CHILD

INSURANCE INFORMATION (you will be notified should any accident or sickness occur, however should emergency assistance be required we will contact and ambulance or emergency worker)

Is this client covered by insurance?	❑ YES	❑ No
Please indicate name of primary insurance		

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment
					$
Client's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

PART 2: PREGNANCY AND BIRTH HISTORY

PRENATAL HISTORY:

Did you have any problems getting pregnant? Please describe: ___________________________________

In what month did you begin prenatal care? ____

Please list anything that is out of the ordinary or any diagnoses received during pregnancy:

BIRTH HISTORY (for the child being evaluated):

1. Hospital where born + city + state: ____

2. Physician's Name: ____

3. Gestational Age at time of delivery (or # weeks early or late): ______________________

4. Length of Labor (in hours)? ____________________

5. Any type of labor stimulation and what was used? ________________________________

6. Any type of pain medication or anesthesia used during delivery (name, type, amount if known)?

Pain relief ________________________ Anti-vomiting _________________________________

Sedation __________________________ Anesthesia ___________________________________

7. What type of delivery (please circle)? Vaginal Cesarean Section = elective or emergency

Presentation: Head, Face, Breech, Transverse Reason for C-section ___________________

Assistance: Forceps, Vacuum, other _______________________________________

8. Did you experience any of the following problems during the labor/delivery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (why, what occurred, how treated etc):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			MATERNAL infection	
2			Low/high red/white blood cell count	
3			Pelvis or cervical problems	
4			Placenta problems	
5			Dysfunctional labor	
6			BABY had the cord around the neck	
7			Cord problems (knots, prolapsed, compression)	
8			Baby had very low or high heart rate	
9			Baby had heart rate decelerations	
10			Fetal distress was noted	
11			Meconium was noted	

9. What was the baby's Birth Weight? _______________ Birth Length ___________________________

10. Number of Days spent in the nursery? _________________NICU or Newborn Nursery? ________________

11. What was the condition of your infant while in the hospital after birth? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, what occurred, how treated etc):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Was blue/cyanotic at birth	
2			Required stimulation to breathe	
3			Required oxygen at birth	How much/what type?
4			Required resuscitation	
5			Was considered small for gestational age	
6			Had tremoring or seizures	Which/for how long?
7			Very low tone	
8			Brain hemorrhage	
9			Anemia and/or transfusions	Which/how many times?
10			Jaundice (yellow)	How much/how treated?
11			Had bruising	
12			Rh incompatibility problems	
13			Infections	
14			Congenital birth defects	
15			Aspiration (meconium or fluid)	Which/how treated?
16			Respiratory distress signs or syndrome	
17			Needed ventilation	What type/how long?
18			Choking or vomiting episodes	
19			Tube feedings	
20			Needed medications	

PART 3: MEDICAL HISTORY OF CHILD

It is very important to have as complete a medical history for your child as possible. Please fill out the grid below, making sure you include an explanation for any question answered "yes". In your explanation, please include your child's age(s) if relevant, any diagnoses made, and any treatments that have occurred.

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Frequent Colds/Respiratory Illness	
2			Frequent Strep throat/sore throat	
3			Frequent Ear Infections (?tubes)	
4			Birth defect/genetic disorder	
5			Lung condition/respiratory disorder	
6			Allergies or asthma	
7			Heart condition	
8			Anemia/blood disorder	
9			Kidney/Renal disorder	
10			Urinary problems/infections	
11			Hormonal problem	
12			Muscle disorder/muscle problem	
13			Joint or bone problems	

ITEM	NO	YES	DESCRIPTION	EXPLANATION
14			Fractured bones	
15			Skin disorder/skin problems (eczema)	
16			Visual disorder/vision problems	
17			Eye infections	
18			Neurological disorder	
19			Seizures or convulsions	
20			Stomach disorder/stomach pain	
21			Vomiting/digestion problems	
22			Failure to gain weight/feeding problems	
23			Constipation/diarrhea problems	
24			Dehydration episodes	
25			Hearing Loss/Ear disorder	
26			Significant accidents	
27			Head injuries or concussions	
28			Ingestion of toxins, poisons, foreign objects	
29			Major medical procedures (detail below)	
30			Chronic medications (for what? when?)	
31			Any major childhood illness (pox, croup, measles, mumps, meningitis etc)	

HOSPITALIZATIONS AND/OR SURGERIES:
List the dates of any hospitalizations your child has had and the reason. List the dates of any surgeries your child has had and the reasons.

1. ______________________________________ 3. _______________________________________

2. ______________________________________ 4. _______________________________________

PRESENT HEALTH STATUS: Most recent Height = ________ Weight = ___________Date: ________

Please note any illnesses for which your child is currently being treated, including their Current Medications:_____

____

____

PART 4: DEVELOPMENTAL HISTORY

We would like to have information about your child's developmental milestones. Indicate the age when your child first did each of the following INDEPENDENTLY. If you can not recall/find a specific age, please mark whether you believe your child accomplished the milestone early, on time or late. If your child has not yet achieved the milestone, write NA in the age column. Please also rate your estimation of the quality of your child's skills.

MILESTONE	AGE	EARLY	ON TIME	LATE		GOOD/FAIR	POOR
Rolled over							
Sat unsupported							
Crawled							
Stood alone							
Walked by self							
Said first words							
Followed simple 1 step directions							
Said 2-3 phrases							
Ate unaided with a spoon/fork							
Dressed self							
Recognized colors							
Counted to 5							
Recognized alphabet							
Toilet trained							

Part 4: Developmental History (continued)

1. Do you feel your child was "faster" or "slower" than his/her peers in any other way? Please explain __________

____

2. If your child is in school, please describe any difficulties or strengths: ___________________________________

____

3. Name of current school: ________________________________ Grade: ___________________________________

   Any special educations services (which, when)?____

   Teacher:____

   Describe any other concerns: ____

4. Has your Child ever been in therapy (eg. Occupational Therapy, Speech Therapy, psychotherapy, Physical Therapy)? Please indicate what type and when, and who the provider was.

Start date – End date	Type of Therapy	Provider Name	Provider contact information

Hearing (Circle)
Has child had a hearing exam? Yes No Date of last known exam: Location:
Result of hearing exam if attended: No Concern/Issues
Ear Infections Yes No
Ear Tube Surgery Yes No # of Tube placements:
Any Dietary Concern? (Please list)

5. Has your child had problems with any of the following (beyond expected for child's age):

NO	YES	DESCRIPTION	EXPLANATION
		Sleeping problems	
		Bed wetting	
		Drooling	
		Thumb sucking	
		Temper tantrums	
		Head banging	
		Breath holding	
NO	YES	DESCRIPTION	EXPLANATION
		Aggression/destructiveness	
		Nervous habits (nail biting etc)	
		Major mood swings	
		Under or over reactive to sounds	
		Under or over reactive to clothing	
		Under or over reactive to taste	
		Under or over reactive to smell	
		Under or over reactive to light	
		Any unusual fears?	

Speech History

What languages are spoken at home? ____

Which are spoken by the child? ____

Which are understood by the child? ____

Indicate when your child first demonstrated the following. (If applicable)
Age Behavior
___________ cooing, pleasure sounds
___________ single words
___________ babbling (ba-ba, da-da, etc)
___________ phrases (go bye-bye, more juice)
___________ jargon (talking own special language)
___________ short sentences

What is the primary method(s) your child uses for letting you know what s/he wants? (select all applicable)
_____ looking at objects _____ pointing at objects _____ gestures
_____ crying _____ vocalizing/ grunting _____ physical manipulation
_____ single words _____ 2-3 word combinations _____ sentences

Which of the following best describes your child's speech? (select all applicable)

_____ easy to understand
_____ difficult for parents to understand
_____ difficult for others to understand
_____ almost never understood by others
_____ different from other children of the same age

Which of the following best describes your child's reaction to his/her speech? (select all applicable)
_____ is easily frustrated when not understood
_____ does not seem aware of speech/ communication problem
_____ has been teased about his/her speech
_____ tries to say sounds or words more clearly when asked
_____ is successful in saying sounds or words more clearly when s/he tries

Does your child have difficulty producing certain sounds? _____ Yes _____ No
If "yes," which ones? ____

Which of the following do you think your child understands?
_____ his/her own name _____ names of body parts _____ family names
_____ names of objects _____ simple directions _____ complex directions
_____ conversational speech

When was speech difficulty first noticed? ______________________________________
By whom? ____

PART 5: FAMILY MEDICAL HISTORY

Are there any of the following medical problems on either side of the child's BIOLOGICAL parents' families? If YES, please indicate on which side of the family, MOTHER or FATHER and explain WHO this is in relation to the CHILD. Please also explain if medications, surgery or hospitalizations were needed.

NO	YES	DESCRIPTION	MOTHER Or FATHER'S SIDE ?	WHO? (as related to your child)	EXPLANATION
		Birth defects/Congenital disorder			
		Neurological disorder or seizures (eg. Alzheimer's, Parkinson's)			
		Allergies - food or environmental (specify which type and for whom)			
		Stomach disease/disorder/problems (eg. Reflux, Colitis, Chron's, Celiac)			
		Senses problems - vision, hearing, touch, taste, smell, balance			
		Swallowing or feeding problems (eg. described as picky eater as child, esophageal strictures)			
		Attentional/learning problems			
		Hyperactivity			
		Alcohol/drug problems			
		Psychological/nervous issues			

CONSENT FOR PHOTO AND VIDEO RECORDING

I understand that The Griffin Promise Autism Clinic will be occasionally use photography and video recording of clinic therapy sessions. I give the clinic the right to use video or photos which contain myself/my child as part of their documentation and property. These photos and videos may be used as part of a training program lead by a Griffin Promise instructor or on social media and marketing material for future camps and clinic programs.

X____

Your signature   Date

I verify that all the information I have provided in this document is true to the best of my knowledge.

X____

Your signature   Date