Bowman Medical Group

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This form is meant to give helpful information about a child up to the age of 17. The information you write on this form will be used to design a treatment program specifically for your child. If you have difficulty remembering some of the information, please write in "cannot remember," but only if you have no recollection at all. If a question is not applicable to your child, write "N/A".

Please print on the line below the name of the person completing this form, and the relationship of this person to the child.

Name of person completing form _____

Relationship to child _____

SECTION I: CHILD IDENTIFICATION

Child's name _____ Date of birth _____ Age ____

Address_____

Birthplace_____Citizenship_____Race_____

Physical description: Height _____ Weight _____ Hair color_____

Religion _____

Adopted: Yes ____ No ____ if yes, give date of legal adoption _____

SECTION II: FAMILY INFORMATION

Family surname _____

Mother's name _____ Date of birth _____

Address_____

Home number_____ Cell phone number_____

Office number_____

Education _____ Child living at home? _____

Occupation _____ Full time_____ Part time_____

Father's name _____ Date of birth _____

Address_____

Home number_____ Cell phone number_____

Office number_____

Education _____ Child living at home? _____

Occupation _____ Full time _____ Part time _____

Stepmother's name _____ Date of birth _____

Address_____

Home number_____ Cell phone number_____

Education _____ Child living at home? _____

Occupation _____ Full time _____ Part time _____

Stepfather's name _____ Date of birth _____

Address_____

Home number_____ Cell phone number_____

Education _____ Child living at home? _____

Occupation _____ Full time _____ Part time _____

Brother/Sisters Name(s)	Sex	Age	Occupation	Relation to child
_____	____	____	_____	_____
_____	____	____	_____	_____
_____	____	____	_____	_____
_____	____	____	_____	_____

Others living in home	Sex	Age	Occupation	Relation to child
_____	____	____	_____	_____
_____	____	____	_____	_____
_____	____	____	_____	_____
_____	____	____	_____	_____

Family Doctor

Name _____ Phone Number _____

Address _____

Section III: Pregnancy, Labor and Delivery, First Months

1. Mother's health during pregnancy: good _____ fair _____ poor _____
2. Any physical problems? _____ If yes, describe: _____

_____

3. Nervous, apprehensive, usually moody? _____ If yes, apparent reason: _____

_____

4. Did mother work? _____ if yes, how long? _____ by choice? _____
5. How did the mother and father feel about the pregnancy? _____

_____

_____

6. Has the mother had any miscarriages or children who died after birth?_____

   If yes, when _____; cause: _____

7. Were any drugs or medications prescribed or used during pregnancy? _____

   If yes, please specify: _____

8. Did the mother experience any spotting or bleeding during pregnancy? _____

   If yes, explain: _____

9. How long did labor last? _____ was it especially difficult? _____
10. Was delivery spontaneous? _____ induced? _____ instruments? _____

    Caesarian? _____

11. Which part of the baby was born first? _____
12. Was the baby full term? _____ If not, how early? _____
13. What was the baby's weight? _____
14. List any injuries or deformities noted at birth: _____

_____

15. Did the baby have difficulty beginning to breathe? _____ was oxygen used? _____
16. How long did the baby stay in the hospital? _____

17. Did the baby have any problems during the first two weeks? _____ If yes, describe:

_____

_____

18. Did the mother experience anything unusual following childbirth? (such as physical complications, unusual nervousness, depression, etc.)

_____

_____

19. Please write in any further information about the mother of the baby during this time that should be reported:

_____

_____

_____

_____

20. Was the baby breast-fed? _____ bottle-fed? _____ both? _____

21. Describe any problems with nursing and/or formula:

_____

_____

_____

22. At what age was the baby completely weaned? _____

23. Describe amount of baby's activity (very active, restless, quiet, etc.)

_____

24. Was either parent, or were both, away from home for more than three days during the baby's first year? _____ If yes, describe the circumstances:

_____

_____

_____

_____

_____

_____

25. Describe anything unusual or stressful (illness, disagreements, separation, other) in the family during the baby's first year:_____

_____

_____

_____

_____

26. Did anyone help the mother with the baby? _____ If yes, who? _____

SECTION IV: EARLY CHILDHOOD

27. At what age did the child get his/her first tooth? _____
    At what age did he/she sit alone? _____ At what age did he/she start crawling? ____
    At what age did he/she start walking alone? _____ At what age did he/she start eating with a spoon? _____ At what age did he/she say his first word? ____ At what did he/she say his first sentence? ____
28. At what age was toilet training completed? _____
29. At what age did he/she show curiosity about sex? _____ Describe the nature of the curiosity, and how it was dealt with: _____

    _____

    _____

    _____

30. If he/she masturbated, what are the parents' attitudes toward this?

    _____

    _____

    _____

31. How did this child react to frustration and/or disappointment?

    _____

    _____

    _____

32. Did he/she have temper tantrums? _____ If yes, at what age? _____

Describe:_____

_____

_____

What caused the tantrums? _____

_____

_____

_____

33. Who usually disciplines the child? _____

What methods were/are being used?_____

34. Has he or she had fears, such as fear of darkness, dogs, etc.? _____

If yes, at what ages? _____ how were these handled? _____

_____

_____

35. Did he or she ever share a room with anyone? _____ If yes, with whom? _____ at what ages? _____ did the child ever share a bed with anyone? _____ if yes, with whom? _____

36. Describe any sleep disturbance, including ages(s):_____

_____

37. Describe any eating problem, including age(s):_____

38. Have there been any sudden changes in sleeping or eating habits? _____ If yes, describe including age(s):_____

SECTION V: COMMUNICATION

39. Have you ever questioned this child's ability to hear normally? _____ If yes why?

_____

_____

40. Has hearing been tested? _____ if yes, results _____

hearing aid? _____ if yes, worn how long? _____

41. Spoke first words at age _____ Examples _____

_____

42. Spoke first sentence at age _____ Examples _____

_____

43. Did the child repeat songs, rhymes, TV commercials, etc? _____

_____

44. Did the child begin to babble or talk and then stop? _____ if yes, explain _____

_____

45. Give an example of typical sentences this child uses now: _____

_____

46. How does he or she make wants known?

_____

47. Which of the following statements describe the child's ability to understand speech (circle the letter in front of the word that describes the child best):

a. Does not understand what is said

b. Understands very little of what is said

c. Understands what is said when speaker gestures

d. Understands familiar statements or questions

Which of the following statements describes the child's ability to express himself or herself ? (circle one letter)

a. Does not use speech or gestures to communicate

b. Uses gestures or motions, but no speech

c. Uses speech, primarily single words

d. Uses speech, stutters

e. Sentences are understood by family, but not by others

f. Sentences are understood by others

g. Speech is clearly understood

48. Has the child ever been in speech therapy? _____ if yes, when? _____ where? _____

49. Add any other information about this child's communication that should be reported:

_____

_____

_____

SECTION VI: SCHOOL/VOCATION

50. Did this child attend preschool? _____ if yes, at what age? _____

kindergarten? _____ at what age? _____ describe any problems _____

_____

_____

SECTION VII: SCHOOL/VOCATION CONTINUES

51. From first grade to date, give the school information for each grade to the current year:

School year	Grade	Age	Name of school	Passed, Retained, Soc. Promoted

If retained, explain _____

_____

52. Describe any problems in school, including age and grade they occurred: _____

_____

_____

53. Describe vocational training, if any:_____

_____

_____

54. List any jobs the child has held:

Job	Location	Date

Parent Questions

Are you currently taking any prescription medications? Y N

What are they? _____

Do you drink coffee, tea or soda containing caffeine? Y N

Number of glasses/cups per day: coffee _____ tea _____ soda _____

Do you drink beer, wine or liquor? Y N

If "yes," when was the last time?

_____

How many days per week do you drink beer? _____ wine? _____ liquor? _____

In the past 30 days did you drink enough to get drunk? _____

Do you smoke cigarettes? Y N

What brand? _____

How many per day? _____

Have you ever smoked marijuana or hashish? Y N

How often, and how long did you use? _____

Have you used in the past 30 days? Y N when? _____

Used cocaine/crack? Y N

How often, and how long did you use? _____

Have you used in the past 30 days? Y N when? _____

Sniffed glue, paint thinner or other substances? Y N

How often, and how long did you use? _____

Have you used in the past 30 days? Y N when? _____

Used LSD or other hallucinogens? Y N

How often, and how long did you use? _____

Have you used in the past 30 days? Y N when? _____

Used heroin or other opiates (codeine)? Y N

How often, and how long did you use? _____

Have you used in the past 30 days? Y N when? _____

Used barbiturates? Y N

How often and how long did you use? _____

Have you used in the past 30 days? Y N when? _____

Which substance is the major problem for you, if any?

_____

SECTION VIII: FAMILY MEDICAL HISTORY

55. In the child's family, on the mother's or the father's side, have any family members had any of the medical conditions listed below? For any known history, please write in the relationship of the family member (including father or mother's side) in the line by the name of the condition. Add any other information you feel is important.

CONDITION	RELATIONSHIP	FURTHER INFORMATION
Congenital defects		
Mental retardation		
Cerebral palsy		
Muscle disorders		
Psychiatric problems		
Emotional problems		

Nervous problems
Heart disease
Eye disorders
Lung or respiratory disorders
Allergies
RH negative blood type
Down's syndrome
Physical deformities
Learning disabilities
Alcoholism
Drug dependence
Sudden infant death
Diabetes
Migraine headaches

Please add any other family medical information that you think should be considered:

_____

_____

_____

_____

_____

_____

SECTION IX: CHILD'S MEDICAL HISTORY

56. Has this child ever been unconscious, blacked out, or had a seizure? _____ if yes, give details:_____

_____

57. Has he or she ever been hit in the head or ear? _____ if yes, describe:_____

_____

58. Does the child have vision problems? _____ if yes, describe:_____

_____

59. Does he or she have hearing problems? _____ if yes, describe: _____

_____

60. Does he or she have coordination problems? _____ if yes, describe: _____

_____

61. Has the child ever had physical therapy? _____ if yes, describe: _____

_____

62. Does he or she have allergies? _____ if yes, describe:_____

_____

63. Has the child reached puberty? _____ what age? _____ reaction? _____

_____

Age menstrual periods started _____ regular _____ irregular _____(check one)

SECTION X: CHILD'S PHYSICAL HEALTH/FITNESS

64. GENERAL HEALTH: good _____ fair _____ poor _____ other _____

65. Please fill in the line with requested information on any of the following illnesses the child has had:

Illness	Age	Mild	Moderate	Severe	Describe any complications
Measles					
Chicken Pox					
Whooping Cough					
Diphtheria					
Scarlet Fever					
Mumps					
Flu					
Pneumonia					
Unusually High Fever					
Tonsillitis					
Sinusitis					

Frequent Colds					
Epilepsy					
Encephalitis					
Meningitis					
Draining Ears					
Polio					
Rubella					
3-day Measles					
Migraines					
Other					

Please add any other information about the child's physical health that you think is important: _____

_____

_____

_____

_____

_____

66. Please fill out the following completely, even if some things do not seem important. Use additional pages if necessary

Operations	Age	Length of hospitalization	How was child prepared? List any aftereffects:
Any other hospitalization	Age	Length of hospitalization	Any aftereffects (fearfulness, sleep disturbance, nervousness, etc.)

Any accidents--state what happened	Age	Unconscious?	Describe treatment and any after aftereffects
Any other illness or persistent condition	Age	Length of illness or condition	Hospital treatment
List any medication child has taken in past	Dose	Reason medication given	Reaction to medication
Medication now being taken	Dose	Name of prescriber	Reason for any reaction to medication

SECTION XI: CURRENT BEHAVIOR

Check either "Yes" or "No" in front of each question below about the child's behavior.

Fill in additional information as indicated.

67. ___ Yes ___ No Gets along well with age mates:

_____

68. ___ Yes ___ No Cries often:

_____

69. ___ Yes ___ No Has temper tantrums:

_____

70. ___ Yes ___ No Does regular tasks or chores at home (list):

_____

71. ___ Yes ___ No Seems extremely active:

_____

72. ___ Yes ___ No Eats well:

_____

73. ___ Yes ___ No Sleeps well:

_____

74. ___ Yes ___ No Is afraid of certain things (such as animals, the dark, etc.):

_____

75. ___ Yes ___ No Wets the bed:

_____

76. ___ Yes ___ No Bites nails:

_____

77. ___ Yes ___ No Sucks thumbs:

_____

78. ___ Yes ___ No Has favorite activities (list):

_____

79. ___ Yes ___ No Behavior is the same from day to day:

_____

80. ___ Yes ___ No Behavior is the same from situation to situation. Explain:

_____

81. ___ Yes ___ No "Hears what he wants to hear", or ignores speech directed to him/her:_____

82. ___ Yes ___ No Shows concern when separated from parents:

_____

83. ___ Yes ___ No Has special talents:

_____

84. ___ Yes ___ No Has deficiencies:

_____

85. Child is _____ right-handed _____left-handed _____ ambidextrous. Has any attempt been made to change handedness? _____Yes _____ No If yes, explain:

_____

_____

86. Describe the child's personality (such as outgoing, cooperative, withdrawn, and so on)

_____

_____

87. In the past 30 days did your child:

a. Smoke cigarettes	Yes	No
b. Drink alcohol	Yes	No
c. Smoke marijuana/ hashish	Yes	No
d. Use cocaine/ crack	Yes	No
e. Sniff glue, paint thinner, or other substance	Yes	No
f. Use LSD or other hallucinogens	Yes	No
g. Use heroin or other opiates (codeine)	Yes	No
h. Use barbiturates	Yes	No

88. Put a check mark in front of any terms below that apply to your child:

____Limited mental ability
____Injured others
____Overly fearful
____Limited physical ability
____Runaway
____Poor eye contact
____Confusion
____Lying
____Inadequate concept of danger
____Hallucinations
____Unacceptable sexual habits
____Suicide attempts
____Suspiciousness
____Learning problems
____Strange behavior
____Depression or sadness
____Victimized by others
____Destructive to property
____Anxiety or nervousness
____Limited communication skills
____Temper tantrums
____Poor impulse control
____Medical problems
____Stealing
____Hates being touched
____Strange or unusual thoughts
____Alcohol abuse
____Suicide threats
____Problems with memory
____Odd movements or habits
____Sudden mood changes
____Talks to self
____Shyness
____Socially inappropriate behavior
____Agitation
____Falsely accuses others

____Panic attacks
____Discipline problems
____Injures self
____Threatens others

89. Check any factors in the columns below that you think might be related to your child's problems:

____ Hearing problem
____ Auditory perception problem
____ Speech problem
____ Language problem
____ Emotional problem
____ Brain injury
____ Rivalry with brothers/sisters
____ Stubbornness
____ Behavioral problems
____ Too much protection by father
____ Neglect by mother
____ Neglect by father
____ Inconsistency of parental handling
____ Mental retardation
____ Environmental problems
____ Reading problems
____ Other learning problems
____ Lack of playmates
____ Behavioral problems
____ Too much protection by mother
____ Others (list):

_____
_____
_____
_____
_____

90. Please list all evaluations that this child has had in the past, including medical, psychiatric, educational, psychological, speech/hearing, and so on, including the location and approximate date. *Please bring a copy of each evaluation with you, if possible.*

EVALUATION	CLINIC, AGENCY OR PROFESSIONAL	ADDRESS	DATE

SECTION XII: PARENTAL EXPECTATIONS

Please describe in your own words your child's difficulties, the goals that you have for this child, and what you expect of his or her treatment and your involvement in the treatment. Include the length of treatment you might expect, and the treatment modalities you think are going to be used.

Father's response:

Mother's response: