



DEVELOPMENTAL HISTORY

Infant - Adolescence

The information supplied in this form is strictly confidential and considered protected health information as defined by HIPAA. Please refer to Connections Chiropractic's HIPAA Privacy Statement for further information.

Patient Information

Person Completing Questionnaire: _____

Relationship to Child: _____

Child's name: _____

Date: _____

Birth Date: _____ Age: _____ Gender: Male Female

What is the main problem that concerns you about your child?

- AD (Attention) HD (Hyperactivity) Tourette's OCD PPD Asperger's
- Autism Anxiety Poor Socialization Dyslexia
- Processing Disorder Learning Disability Motivation Depression
- Other _____

Please describe your child's symptoms. Elaborate on the check-marked items above.



Is the child performing at school level? Yes No If no, please provide details below: _____

Family History

Parents are: Married Divorced Separated Widowed Other

Mother's Name: _____

Occupation: _____

Mother is: Right Handed Left Handed Ambidextrous (uses either hand)

Siblings — indicate full name and age:

1. Name: _____

_____ Age: _____

2. Name: _____

_____ Age: _____

3. Name: _____

_____ Age: _____

4. Name: _____

_____ Age: _____



Family History Cont.

What is the past medical history of the parents? Any significant mental or physical diagnoses in the past (i.e., depression, vertigo, heart disease, etc.)? Please describe details below:

Any drug or alcohol abuse by parents during or before pregnancy? Yes No (if yes, please describe)

How was the mother's health before pregnancy? Excellent Good Fair (please describe)

How was the mother's health during pregnancy? Excellent Good Fair (please describe)

Child's Developmental History

Was there any problem with your child's birth that was not mentioned above?

Premature Late Long Labor Oxygen Deprivation Forceps or Vacuum Extraction C-Section

How was your child's health after birth? Excellent Good Fair

Has your child had any of the following: Colic Vomiting Constipation

(If checked, please describe) Diarrhea Gastric Reflux Pyloric Insufficiency

Is there a history of chronic ear infections? Yes No If yes, how many? _____

Were antibiotics used? Yes No Sometimes

Does your child have any sensitivity to: Smell/Scents Sound Touch Light

Does your child have problems with: Hearing Vision

Has your child had any reactions to vaccinations? Yes No If yes, explain: _____

Was your child adopted? Yes No If yes, at what age? _____





Child's Developmental History Cont.

PHYSICAL & BEHAVIORAL DEVELOPMENT

What is your child's current weight? _____ Current Height? _____

Any period of rapid weight loss? Yes No (If yes, please describe)

How many consecutive hours does your child sleep each night? _____

Is your child a sound sleeper? Yes No Does your child sleepwalk? Yes No
Does your child have nightmares? Yes No Does your child take naps? Yes No

How many hours a day does your child spend doing the following activities? Try to be accurate.

Television	<input type="checkbox"/> 0-1 hrs	<input type="checkbox"/> 1-2 hrs	<input type="checkbox"/> 2-3 hrs	<input type="checkbox"/> 3-4 hrs	<input type="checkbox"/> 4-5 hrs	<input type="checkbox"/> 5-6 hrs
	<input type="checkbox"/> 6-8 hrs					
Computer Work	<input type="checkbox"/> 0-1 hrs	<input type="checkbox"/> 1-2 hrs	<input type="checkbox"/> 2-3 hrs	<input type="checkbox"/> 3-4 hrs	<input type="checkbox"/> 4-5 hrs	<input type="checkbox"/> 5-6 hrs
	<input type="checkbox"/> 6-8 hrs					
Video Games	<input type="checkbox"/> 0-1 hrs	<input type="checkbox"/> 1-2 hrs	<input type="checkbox"/> 2-3 hrs	<input type="checkbox"/> 3-4 hrs	<input type="checkbox"/> 4-5 hrs	<input type="checkbox"/> 5-6 hrs
	<input type="checkbox"/> 6-8 hrs					

What does your child typically eat:

For breakfast: _____

For lunch: _____

For dinner: _____

For snacks: _____

Is your child picky with certain foods? Yes No If yes, which foods?

Does food texture or consistency bother your child? Yes No If yes, which textures/consistencies?

Is your child bashful, shy, or very social? Bashful/shy Social



Child's Developmental History Cont.

- Does your child have many friends? Yes No
- Does your child have any speech problems? Yes No Describe: _____
- How long does it take to do schoolwork at night? _____
- Does your child recognize if other people are happy, sad, or angry? Yes No
- Is your child right handed or left handed? Right Handed Left Handed Ambidextrous
- What does his/her handwriting look like? Messy Neat Stays within lines
- At what age did your child walk? _____
- Did your child crawl before walking? Yes No For how long? _____
- Was there an abnormal crawl, shuffle, or slide? Yes No Describe: _____

Behavioral Checklist

Please rate according to the following scale the severity of all the following symptoms your child may have:

0****1****2****3****4****5****6****7****8****9****10
 None Moderate Severe

During Meals		At Play	
Up & down at table		Inability for quiet play	
Interrupts without regard		Constantly changing activity	
Fiddles with things		Seeks parental attention	
Talks excessively		Talks excessively	
Television		Disrupts others' play	
Gets up & down during programs		Difficulty waiting turn	
Manipulates objects &/or body		Lethargy (couch potato)	
Talks incessantly		Poor Athletic ability	
Interrupts		Poor fine motor coordination	
During Homework		Lack of imagination/pretense	
Gets up & down		Medical	
Manipulates objects &/or body		Scoliosis	
Requires adult supervision		Cramping of hands & feet	
Behavior Away From Home		Chronic infections	
Restlessness during travel		Sleep	
Restlessness during shopping		Difficulty settling down for sleep	
Restlessness during church/ meetings		Inadequate amount of sleep	
Restlessness while visiting others		Restless during sleep	
Social withdrawal/shyness		Excessive sleepiness	



Past Evaluations

Please indicate if your child has had any of the following evaluations, treatment, or consultations by placing a checkmark in the box. Please indicate the date if possible. If you have copies of reports and/or the location where the evaluations took place, please attach this information. Feel free to add comments below, on the back of this page or attach a sheet if needed.

<u>EVALUATION</u>	<u>YES</u>	<u>DATE</u>
Psychological evaluations	<input type="checkbox"/>	_____
Wechsler preschool & primary scale of intelligence	<input type="checkbox"/>	_____
Speech & language evaluations	<input type="checkbox"/>	_____
Genetic evaluations	<input type="checkbox"/>	_____
Neurological evaluations	<input type="checkbox"/>	_____
Gastroenterology evaluations	<input type="checkbox"/>	_____
Celiac/gluten testing	<input type="checkbox"/>	_____
Allergy evaluation	<input type="checkbox"/>	_____
Auditory evaluation	<input type="checkbox"/>	_____
Vision evaluation	<input type="checkbox"/>	_____
Osteopathic	<input type="checkbox"/>	_____
Acupuncture	<input type="checkbox"/>	_____
Physical therapy	<input type="checkbox"/>	_____
Occupational therapy	<input type="checkbox"/>	_____
Sensory integration therapy	<input type="checkbox"/>	_____
Language classes	<input type="checkbox"/>	_____
Sign language	<input type="checkbox"/>	_____
Homeopathic	<input type="checkbox"/>	_____
Naturopathic	<input type="checkbox"/>	_____
Craniosacral	<input type="checkbox"/>	_____
Chiropractic	<input type="checkbox"/>	_____
Other _____		_____

Additional Comments:



Parent / Legal Guardian Authorization

I hereby certify that the statements made and answers given on this form are accurate to the best of my recollection and knowledge. I understand that the information on this form will become a permanent part of the patient's medical records.

I agree to allow Connections Chiropractic Center to examine my child for further evaluation.

375 Four Leaf Lane, Suite 202
Charlottesville, VA 22309
434.823.2199
www.connectionschiropractic.com

