



Family History					
Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your <b>blood relatives</b> had any of the following and describe their relationship to you.
Father					<input type="checkbox"/> Aneurysms_____ <input type="checkbox"/> Heart Disease_____
Mother					<input type="checkbox"/> Anxiety_____ <input type="checkbox"/> High Blood Pressure_____
Brothers					<input type="checkbox"/> Arthritis, gout_____ <input type="checkbox"/> Kidney Disease_____
					<input type="checkbox"/> Asthma_____ <input type="checkbox"/> Learning Disabilities_____
					<input type="checkbox"/> Autism_____ <input type="checkbox"/> Bipolar Disorder_____
					<input type="checkbox"/> Brain Tumors_____ <input type="checkbox"/> Mental Retardation_____
Sisters					<input type="checkbox"/> Cancer_____ <input type="checkbox"/> Muscular Disease_____
					<input type="checkbox"/> Cerebral Palsy_____ <input type="checkbox"/> Obsessive Compulsive DO_____
					<input type="checkbox"/> Chemical Dependency_____ <input type="checkbox"/> Schizophrenia_____
					<input type="checkbox"/> Depression_____ <input type="checkbox"/> Syphilis_____
					<input type="checkbox"/> Epilepsy/Seizures_____ <input type="checkbox"/> Tics_____
					<input type="checkbox"/> Gonorrhea_____ <input type="checkbox"/> Tuberculosis_____
				<input type="checkbox"/> Headaches/Migraines_____ <input type="checkbox"/> Other infectious Disease_____	

**Academic Performance**

- Excellent  Average  Poor

Which areas are difficult? \_\_\_\_\_

**Behavior**

- Excellent  Variable  Disruptive

**Is there a history of:**

- |   |  |                                 |
|---|--|---------------------------------|
| <input type="checkbox"/> Biting           | <input type="checkbox"/> Bed Wetting               | <b>Sensitivity to</b>           |
| <input type="checkbox"/> Hitting          | <input type="checkbox"/> Stuttering                | <input type="checkbox"/> sound  |
| <input type="checkbox"/> Head banging     | <input type="checkbox"/> Teeth grinding at night   | <input type="checkbox"/> touch  |
| <input type="checkbox"/> Aggressiveness   | <input type="checkbox"/> Teeth grinding in the day | <input type="checkbox"/> smells |
| <input type="checkbox"/> Odd fascinations | <input type="checkbox"/> Pulling own hair          | <input type="checkbox"/> lights |

**How is his/her play?**

- Appropriate  Inappropriate

**How does (s)he interact with other children?**

- Very well  Average  Poorly

**Abnormal Movements**

- None  Excessive turning  Hand flapping  Tics

**Sleep Pattern**

- Normal  Difficulty falling asleep  Frequent waking  Nightmares  Night terrors  Other\_\_\_\_\_

**Vision:**

Vision tested?  Yes  No If yes, what were the findings? \_\_\_\_\_

Hearing tested?  Yes  No If yes, what were the findings? \_\_\_\_\_ Excessive wax? \_\_\_\_\_

**Excessive fears**

- |                                      |  |   |
|--------------------------------------|--|---|
| <input type="checkbox"/> Water       | <input type="checkbox"/> Night Terrors | <input type="checkbox"/> Animals. Which ones? |
| <input type="checkbox"/> Being alone | <input type="checkbox"/> Thunder       | _____   |
| <input type="checkbox"/> Dark        | <input type="checkbox"/> Strangers     | _____   |
|                                      |  | <input type="checkbox"/> Other. _____         |

**Please briefly describe the reason for your visit:**

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