

Pediatric History / Parent Questionnaire

Prenatal History:

Birth Weight _____ Height _____ Duration of Pregnancy _____

Type of Delivery: _____

Complications at Birth: _____

Treatment Received by baby and/or mother: _____

Please list any injuries, illnesses, infections, hospitalizations, surgeries or other medical procedures your child has had and the ages these occurred: _____

Does the child have any allergies, seizures or other medical problems? _____

Current Medications: _____

Developmental Milestones: at what age did your child do the following?

Roll back to stomach _____

Roll stomach to back _____

Sit unsupported _____

Sit supported _____

Pull to stand _____

Crawl _____

Cruise _____

Walk _____

Climb stairs _____

Run _____

Begin eating solid foods _____

Finger feed self _____

Use utensils _____

Drink from cup _____

Living Arrangement (where, with whom, siblings, pets): _____

How does your child spend their day? (Preschool, school, daycare, home, etc.):

Please describe your concerns for this child: _____

What does your child like/dislike?

Is there anything else you would like us to know about your child? _____

