Myers Park
Michele Mannering PhD
Pediatric Psychology

Date:_____

Demographic Information

Child's Name	
Child's Date of Birth	
Mother's Name	
Father's Name	
Home Address	
Home Phone	
Cell Phone	
Parent email	

Pediatrician	
Pediatrician Phone	
Other Involved Physicians	
Other Involved Service Providers	

Current School	
Current Grade	
Current Teacher	
Teacher Email	

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Birth History

Birth order of this child: _____

How many other children are in the family? _____

Were there any health complications during the pregnancy? If yes, describe: _____

_____

How long was the pregnancy: _____

Birth weight: _____

Apgar Scores:_____

Mode of Delivery: _____

Were there complications at delivery? If yes, please explain: _____

_____

Did the child go to the special care nursery or NICU? ☐ Yes ☐ No
If yes, explain:

_____

Did your child have any problems in the first days of life? ☐ Yes ☐ No
If yes, explain:

Did your child have feeding problems as a newborn or infant? ☐ Yes ☐ No
If yes, explain

How long did your child stay in the hospital before going home? _____

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Developmental History

Skill	At what age did this skill begin?	Comments
Sit independently		
Walk		
Wave Bye Bye		
Point		
Show objects to others		
Imitate others actions		
Say First Word		
Use 2 word combination		
Engage in Pretend/Imaginary Play		
Show interest in other children		
Master toilet training		
Write name/letters		
Show interest in counting		
Identify colors		

Has your child ever lost skills or regressed? If yes, please explain: _____

_____

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Medical Information

Has your child ever:	Date	Reason and/or Results
Been to the emergency room?		
Been hospitalized?		
Had surgery?		
Had any serious accidents?		
Had any chronic medical conditions?		
Had any allergies?		
Had genetic testing?		
Been to a neurologist?		
Had an MRI or CT scan?		
Had an EEG?		
Had a hearing test?		
Had a vision test?		
Had any other medical tests?		

Medication History

Does your child take:	Current or Past?	Type/Name
Prescription Medications?		
Over the counter medications Including vitamins		
Complementary or alternative medications?		

		If yes, please explain:
Does your child have any difficulties with sleep: falling asleep, staying asleep, restless sleep?	☐ Yes ☐ No	
Does your child have any food aversions or sensitivities? Is he/she a picky eater?	☐ Yes ☐ No	
Does your child seem bothered by light?	☐ Yes ☐ No	
Does your child seem bothered by certain sounds/noises?	☐ Yes ☐ No	
Is your child sensitive to having his/her nails cut, hair combed, teeth brushed or face washed?	☐ Yes ☐ No	
Is your child clumsy?	☐ Yes ☐ No	
Does your child have any trouble with handwriting?	☐ Yes ☐ No	

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School History

Please list past schools attended

School Name	Dates	Age	Type of Setting

Previous Evaluation and Service History

Please list below any testing done with a psychologist, speech and language pathologist, occupational therapist or other therapist.

Test Done	Clinician	Findings	Recommendations

Does anyone in your immediate or extended family have/or had any of the following problems?

			Family Member
Learning disabilities?	☐ Yes	☐ No	
Attention Deficit Hyperactivity Disorder (ADHD)	☐ Yes	☐ No	
Depression or Anxiety?	☐ Yes	☐ No	
Autism Spectrum Disorder?	☐ Yes	☐ No	
Mental Retardation or Developmental Delay?	☐ Yes	☐ No	
Language delays or Late to Talk?	☐ Yes	☐ No	

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Current Functioning

What are your child's favorite activities?

What are your child's strengths?

How would you describe your child's ability to learn and use new information?

How would you describe your child's ability to handle stress and frustration?

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What is the main concern you have about your child, and when did this first appear?

What have you done to address this problem to date?

Do you have any additional concerns, and if yes, when did they first appear?

Completed by: _____