Wellington-Alexander
CENTER
DYSLEXIA ASSESSMENT & INTERVENTION

CHILDREN'S MEDICAL HISTORY

GENERAL INFORMATION

Child's Name: _____ DOB: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Reason for consultation: _____

_____

What are your main concerns? _____

_____

Child lives with:

- □ Birth parents
- □ Adoptive parents
- □ Foster parents
- □ Parent and step-parent
- □ One Parent
- □ Other: _____

Parent/Caregiver Name	Phone Number	Email
1.		
2.		
3.		

Other children in the home:

Name	Age	Sex	Speech/Hearing Difficulties/Diagnosis?

Has your **child** had any of the following? ***Please mark all that apply.***

- □ Adenoidectomy
- □ Allergies
- □ Chronic Ear Infections
- □ Ear tubes
- □ Encephalitis
- □ Meningitis
- □ Measles
- □ Mumps
- □ Pneumonia
- □ Lung problems
- □ Asthma/RAD
- □ Scarlet fever

- □ Head injury
- □ Heart problems
- □ High fevers
- □ Thumb or finger sucking
- □ Tonsillitis/tonsillectomy
- □ Surgeries
- □ Depression
- □ Other: _____
- □ Seizures
- □ Failure to thrive
- □ Cleft lip/palate
- □ Hearing loss
- □ ADHD
- □ Anxiety
- □ Visual defects

Other hospitalizations? _____

Current medications: *Please list name, dosage and frequency.* _____

_____

Adaptive equipment/assistive technology: _____

Y N Do you have any concerns with your child's vision? _____

Last vision evaluation date: _____

Y N Does your child wear glasses? □ Near-sightedness □ Far-sightedness

Y N Do you have any concerns with your child's hearing? _____

Last hearing screening date: _____

Y N Do you have any concerns regarding your child's oral health? _____

Last dental examination: _____

Y N Has your child had a history of or currently experiencing projectile vomiting?

Y N Does your child experience choking or gagging when eating?

Y N Does your child have a history of or currently have chronic diarrhea?

Y N Does your child have a history of or currently have chronic constipation?

Y N Does your child experience poor management of saliva?

Y N Has your child ever had a modified barium swallow study?

Additional comments: _____

_____

Pediatrician's name and telephone number: _____

Do you want to release information to your pediatrician? **Y** **N** *If yes, please complete a medical release*

Does your child have a diagnosis? **Y** **N**

If so, please list: _____

How would you like to receive a copy of the completed evaluation report?

□ Hard copy sent to my home address?
□ Email copy of the report sent to the following email address: _____

EDUCATIONAL HISTORY

Did or does your child attend pre-school? _____

What grade is your child in? _____

What is the name of your child's school? _____

What district is the school in? _____

Is your child in… □ general education □ resource □ Self-contained classroom

Is your child receiving any of the following services at the school?

□ Speech □ OT □ PT □ Adaptive P.E. □ Reading

Does your child have an IEP or 504? **Y** **N** *If yes, please describe:* _____

What is your child's teacher's name? _____

Is it okay to contact the teacher? **Y** **N** *If yes, please complete a medical release*

Any concerns with academic skills? _____

Have you obtained any help privately for your child? **Y** **N** *If yes, please explain:* _____

What grades has your child mostly received in the past year: A's & B's B's & C's C's & D's D's & F's

Check all that apply to your child:

□ Outstanding □ Good □ Satisfactory □ Needs improvement □ Unsatisfactory

Are these grades changed from the previous years? **Y** **N**

In what subject does your child excel? _____ What is the most difficult? _____

Has your child been absent from school due to illness or injury? **Y** **N** *If yes,* □ Less than 2 weeks

□ 2-4weeks □ 5-8 weeks □ Over 8 weeks *Briefly explain the reason for the absence:*

Any concerns with social skills? _____

Hand preference: _____

CURRENT LANGUAGE /COMMUNICATION- ***Please mark all that apply to your child.***

Does your child:

- □ Repeat sounds, words or phrases over and over
- □ Retrieve/ point to common objects upon request
- □ Follow simple directions?
- □ Respond correctly to yes/no questions?
- □ Understand what you are saying
- □ Respond correctly to wh-questions?

What does your child currently use to communicate?

- □ Joint Attention
- □ Sounds (vowels, grunting)
- □ Words
- □ 2-4 word phrases
- □ Sentences
- □ Augmentative Communication Device

At what age did your child do the following? *Indicate "N" if they have not yet accomplished it or if unknown, please approximate as early, average or late.*

- Cooed/babbled _____
- Put 2-3 words together _____
- First word _____
- Followed 1-step direction _____

BEHAVIORAL HISTORY- ***Please mark all that apply to your child.***

Behavior Characteristics:

- □ Impulsive
- □ Cooperative
- □ Attentive
- □ Willing to try new activities
- □ Restless
- □ Poor eye contact
- □ Prefers to Play alone
- □ Aggressive
- □ Avoids certain textures/temperatures, list: _____
- □ Separation difficulties
- □ Self-abusive behavior
- □ Seeks/avoids movement (*circle*)
- □ Distracted or avoidant of loud noises
- □ Easily frustrated
- □ Withdrawn
- □ Plays with others
- □ Easily distracted/short attention

PREGNANCY- ***Please circle "Y" for yes and "N" for no***

- Y N Bleeding
- Y N Excessive weight gain
- Y N Limited weight gain
- Y N Toxemia
- Y N Seizure disorder
- Y N Maternal drug/alcohol/ tobacco use (*circle*)
- Y N Pre-term labor
- Y N Gestational diabetes
- Y N Infections
- Y N Multiple births

Other: _____

Maternal medications: _____

DELIVERY-*Please circle "Y" for yes and "N" for no*

Y N Difficult birth
Y N Prolonged labor
Y N Breech birth
Y N Brief labor
Y N Cesarean sections

Y N Baby had respiratory distress
Y N Oxygen needed for child
Y N Cord around baby's neck
Y N Umbilical cord knot
Y N Baby treated for jaundice

Other complications: _____

Were any of the following used during delivery: □ epidural □ forceps □ Vacuum suction

Days in hospital before discharge: _____

Baby's weight: _____

Length of pregnancy: _____

NEWBORN/NURSERY-*Please circle "Y" for yes and "N" for no*

Y N NICU stay
Y N Breathing machine
Y N Brain Bleed
If yes, grade I II III IV (*please circle*)
Y N Was it resolved?
If no, please explain _____

Y N Sucking difficulties
Y N Hearing screening: Pass /Refer

DEVELOPMENTAL HISTORY

At what age did your child do the following? *Indicate "N" if they have not yet accomplished it or if unknown, please approximate as early, average or late.*

Fine Motor	
• Point with index finger	• Finger feed
• Ate with spoon	• Cut with scissors
• Ate with knife and fork	• Drew a circle
• Removed clothing	• Put on clothing
• Put shirt on independently	• Buttoned independently
• Zipped independently	• Toilet trained
• Combed hair	• Bathed independently
• Tied shoes	

Gross Motor	
• Lift head when laying on stomach	• Head roll
• Roll both ways	• Sat alone
• Crawl	• Walk
• Jump	• Hop on 1 foot
• Pedal a tricycle	• Rode bike

FEEDING-*Please circle "Y" for yes and "N" for no*

Y N Do you have any concerns with your child's feeding skills or variety of foods?

If so, please explain _____

Y N Does your child eat "**non**" food items? *If so, please explain* _____

FAMILY MEDICAL HISTORY-*Please mark all that apply.*

Has any immediate or extended family member experienced the following? *Please check all that apply.*

- □ Hearing Problems
- □ Learning Problems
- □ Intellectual Disability
- □ Autism
- □ Seizure Disorder
- □ Congenital Disorder
- □ Stuttering

What is the primary language spoken in the home? _____

Please add any additional information: _____