Child's Health History:

Patient Name:_____ **DOB:** _____

Assessment Date: _____

Height_____ **Weight** _____ (to be filled out by nurse on day of appointment.)

Temperature _____ (to be filled out by nurse on day of appointment.)

Parent/Guardian: Please explain briefly why you are bringing your child to the NSC:

_____

_____

_____

DEVELOPMENTAL DIAGNOSES:

Developmental Diagnosis Information:

Diagnosis Name (s):

_____

_____

_____

Professional Making Diagnosis: _____

Diagnosis Date: _____

Developmental Disorder Onset: (select one)

____ **Normal Development followed by Regression**

Normal development to at least 12 months followed by loss of skills together with onset of autistic like behaviors.

____ **Normal Development followed by Plateau**

Normal development to at least 12 months followed by a plateau of communications, social cognitive and/or developmental skills together with onset of autistic like behaviors. No loss of previously gained skills.

____ **Developmental difficulties prior to 12 months**

____ **No developmental difficulties**

Other :

_____

_____

_____

_____

Medications: List all medications your child is currently taking.

Supplements: List all supplements your child is currently taking.

ALLERGIES:

Drug Allergy Information: List all drug allergies, symptoms, and if they are known or suspected.

Food Allergy Information: List all food allergies, symptoms, and if they are known or suspected.

CONCERNS ASSESSMENT:

Concerning Issues or Behaviors: (Please list in descending order – greatest concern #1, etc.)

Concern #1: _____

Concern #2: _____

Concern #3: _____

Concern #4: _____

Concern #5: _____

ASSESSMENTS:

NEUROLOGICAL ASSESSMENT: Parent Description:

_____

_____

_____

Symptoms

	Rating			
	None	Mild	Moderate	Severe
Expressive Language Deficit				
Receptive Language Deficit				
Social Integration Issues				
Physical Self Stimulatory Behavior				
Verbal Self Stimulatory Behavior				
Attention Deficits (focusing, concentration)				
Anxiety				
Obsessive Compulsive Behaviors				
Rigid Need for Routine				
Eye Contact Deficits				
Visual-Motor Skills Difficulties				
Hyperacusis				
Sleep Pattern Disruptions				
Toe Walking				
Headaches				
Short Memory				
Aggression				
Imbalance/Clumsiness				
Seizures				
Recurrent Falls				
Spinning objects or self				
Fear of Danger				
Inappropriate Emotions				

Comments:

_____

_____

_____

Patient's Previous Illnesses: Please check all that apply.

____ Coli
____ Reflux
____ Croup
____OCD
____Herpes/Cold Sores
____Chicken Pox
____Trouble Falling Asleep
____Allergic Rhinitis
____ Ear Tubes
____ Tonsillitis
____ RSV
____Seizures
____Meningitis
____ Tics
____Trouble Staying Awake
____ Ear Infections
____ Other
____ Recurrent Sinusitis
____ Adverse Vaccine Reaction
____ Asthma
____ Encephalitis
_____ Frequent Viral Infections
_____ Pneumonia
_____ Strep Throat
_____ Mononucleosis

Family History: Check and indicate relationship to patient.

____ Anxiety Disorder
____ Diabetes
____ Schizophrenia
____Seizures
____ Dyslexia
____Cancer
____ Lupus
____ Autoimmune Disease
____ Dizziness/Vertigo
____ Asperger's
____Depression
____ Parkinson's Disease
____ Speech Disorder
_____ Thyroid Disease
_____ Headaches/Migraines
_____ Scleroderma
_____ Multiple Sclerosis
_____ ADD/ADHD/Autism
_____Alzheimer's Disease
_____ OCD
_____ Bipolar
_____ Allergies (airborne)
_____ Arthritis
_____ Meniere's Disease
_____Heart Disease
_____ TIA's/Stroke
_____ Hypertension

Education:

Current School: _____

Type of School: ____ Public ____ Private _____Charter ____Cyber ____Other (_____)

Grade: _____ Does child have IEP _____ 504 _____

What subject does the child enjoy in school? _____

What subject does the child dislike in school? _____

Have there been any recent changes in the child's grades _____Yes _____No

If Yes, describe: _____

_____

Check the descriptions that specifically relate to your child:

Feelings about School Work:

- ☐ Anxious
- ☐ Fearful
- ☐ Bored
- ☐ Passive
- ☐ Eager
- ☐ Rebellious
- ☐ Enthusiastic
- ☐ No Expression
- ☐ Other:

Approach to School Work:

- ☐ Organized
- ☐ Interested
- ☐ Refuses
- ☐ Disorganized
- ☐ Responsible
- ☐ Self-directed
- ☐ Does only what is expected
- ☐ Cooperative
- ☐ Doesn't finish work
- ☐ No Initiative
- ☐ Sloppy
- ☐ Other

Optometrist/Ophthalmologist:_____

Date of Last Exam:_____ Glasses: ____YES ____NO ____ Contacts

Does your child have any of the following:			**Explain**
Eye turns in/out	Yes	No	_____
Covers/closes one eye a lot	Yes	No	_____
Doesn't seem to focus	Yes	No	_____
Blinks excessively	Yes	No	_____
Poor tracking/eye movements	Yes	No	_____
Head tilt/Face turn	Yes	No	_____
Double Vision	Yes	No	_____
Frequent Headaches	Yes	No	_____
Light Sensitivity	Yes	No	_____
Stumbles over objects or is clumsy	Yes	No	_____
Poor fine/motor control	Yes	No	_____
Any Patching	Yes	No	_____
Any therapy	Yes	No	_____

Does your child verbalize any problems/complaints about his/her eyes or vision? Yes No

If yes, explain_____

_____

Primary Care Physician:_____ **Date of last exam:**_____

Other physicians treating your child:_____

_____

Parent Signature_____ **Date**_____