



2500 Red Hill Ave. Suite 100
Santa Ana, CA 92705
949.267.0400

Patient Sticker Here

Patient History Form

Date Form Completed: ___/___/___
Mo Day Yr

Person completing form: _____
Name

Relationship to patient

Patient's Name: _____ Birth Date: ___/___/___ Age: _____ Sex: M / F
Mo Day Yr

Address: _____
Street City State Zip

Phone: Home: (____) _____ Work: (____) _____ Cell: (____) _____ E-mail: _____

Referred by (name): _____

Self Physician School Agency Friend the Media Other _____

Primary Medical Care Provider: _____ Phone: (____) _____

Address: _____
Street City State Zip

Specialty: Pediatrics Family Practice Internal Med. Nurse Practitioner

Primary Contact Person:

Name: _____ Relationship _____

Address: _____
Street City State Zip

Phone: Home: (____) _____ Work: (____) _____ Cell: (____) _____ E-mail: _____

Information is same as patient: Address Home Phone Work Phone Cell Phone Email

Additional Contact Person (e.g. social worker, family members):

Name: _____ Relationship _____

Address: _____
Street City State Zip

Phone: Home: (____) _____ Work: (____) _____ Cell: (____) _____ E-mail: _____

Information is same as patient: Address Home Phone Work Phone Cell Phone Email

**Please indicate how you would prefer to be contacted (e.g. email/phone/mail)? _____

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CURRENT DIAGNOSES

What are your child's current diagnoses? N/A

CURRENT CONCERNS AND/OR REASONS FOR REFERRAL

1. _____

2. _____

3. _____

Is anyone concerned your child has **autism**? Yes / No **ADHD**? Yes / No **OTHER** ? _____ Yes / No

PRENATAL/BIRTH HISTORY (uk=unknown)

Age when patient was born: Mom _____ Dad _____

Birth place: City _____ State _____ Hospital/Clinic _____

Was child product of a multiple birth? **Y / N / UK** **Twin / Triplet / Quadruplet** Were babies identical? **Y / N / UK**

Totals: # of pregnancies _____ # of live births _____ # of miscarriages _____

Mother's health during pregnancy:

- | | |
|---|--|
| <input type="checkbox"/> Unknown | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Dehydration | <input type="checkbox"/> Bleeding/Spotting |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Serious Infections (Example: Flu, measles, CMV) |
| <input type="checkbox"/> Toxemia (High Blood Pressure/Tremors, etc) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression/mental health issues |
| <input type="checkbox"/> Hospitalization Reason: _____ | |

Exposures during pregnancy:

please circle the appropriate trimester

Smoking	Y / N / UK	Trimester 1,2,3	Amount/day:
Alcohol	Y / N / UK	Trimester 1,2,3	Amount/day:
Caffeine	Y / N / UK	Trimester 1,2,3	Amount/ day:
Street drugs/other	Y / N / UK	Trimester 1,2,3	
Prenatal Vitamins	Y / N / UK	Trimester 1,2,3	
Folic Acid (supplement separate from vitamin)	Y / N / UK	Trimester 1,2,3, Prior to Pregnancy	
Antidepressant Medications	Y / N / UK	Trimester 1,2,3	
Other Medication(s) (_____)	Y / N / UK	Trimester 1,2,3	



PRENATAL/BIRTH HISTORY CONT.

Prenatal Tests:

Ultrasound	Y / N / UK
Maternal Serum Alpha-Fetoprotein (MSAFP)	Y / N / UK
/Triple Screen blood test	
Amniocentesis	Y / N / UK

If abnormal, please explain: _____

Did you experience significant stress during pregnancy? (i.e. separation from spouse, divorce, loss of job, etc) **Y / N / UK**

If yes, please explain: _____

BIRTH HISTORY

Problems with the labor and/or delivery: **Y / N / UK**

If yes, please explain: _____

Number of weeks pregnant when baby was born _____ weeks

Baby was born: head first breech (Feet first) vaginal delivery C-section

If C-Section, please explain why: _____

Birth weight _____ lbs _____ oz length _____ in. head circumference _____ in.

Were there newborn problems?

- | | |
|---|--|
| <input type="checkbox"/> In NICU Y / N / UK (# _____ days) | |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> RH blood type incompatibility |
| <input type="checkbox"/> ABO blood type incompatibility | <input type="checkbox"/> Infection |
| <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> Breathing Issues / On oxygen |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Birth defects |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Other _____ |

Was the child discharged home with mom? **Y / N** If not, why not _____

DEVELOPMENTAL HISTORY

It may be helpful to review infant/toddler milestone books or past reports when completing the following questions. If you are uncertain, estimate as best as you can. Please record the ages in months.

Smiled in <u>response</u> to others	Y / N	_____ months	First words (other than mama and dada)	Y / N	_____ months
Rolled over	Y / N	_____ months	Spoke in 2-word phrases	Y / N	_____ months
Sat without support	Y / N	_____ months	Spoke in full sentences (at least 4 words)	Y / N	_____ months
Crawled	Y / N	_____ months	Bladder control (daytime)	Y / N	_____ months
Stood alone	Y / N	_____ months	Bladder control (nighttime)	Y / N	_____ months
Walked independently	Y / N	_____ months	Bowel control	Y / N	_____ months

At what age did you first notice problems (developmental delays or differences) or have concerns about your child in:

Motor skills (fine, gross motor)	_____ months
Speech and language	_____ months
Social development	_____ months
Problem solving	_____ months
Behavior	_____ months
Play	_____ months
Other	_____ months

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DEVELOPMENTAL HISTORY CONT.

Did your child experience a significant loss of an acquired skill or skills (not just a delay in acquiring the skill)? If so, please indicate:

- Motor coordination explain: _____
- Speech / language explain: _____
- Social functioning explain: _____
- Problem solving explain: _____
- Bladder/bowel control explain: _____

BEHAVIOR ISSUES (for your child)

- Anxious or worries
- Aloof / Doesn't notice things/people
- Short attention span
- Hyperactivity
- Less active than you'd expect
- Obsessive-compulsive
- Aggressive
- Hurting animals or other people
- Sensory problems
- Unusual or excessive fears
- Shy / Slow to warm up
- Depressed/sad
- Impulsive
- Picky eater / Restricted diet
- Defiant
- Self injury (head banging, biting, scratching, cutting, etc.)
- Toileting issues, accidents

Please describe:

Please describe your discipline strategies:

CHILD'S EDUCATIONAL HISTORY *Please bring copies of all educational testing to your appointment*

School name: _____ Phone: _____

Grade in school: _____ (ever repeat a grade? Yes / No) Teacher (or best contact): _____

IEP 504 Plan Special Ed Therapy: OT/PT/SLT

Grades: Math _____ Reading _____ Language _____ Science _____ Social Studies _____

Are there any concerns with friends or bullying? **Y / N / UK**

If yes, please explain:

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What best describes your child's current educational program?

- Not Applicable
- Full time in a regular class
- Regular class supplemented by resource specialist room/learning lab time
- Time split between regular and special education classes
- Special education class in a school district
- Aide/Paraprofessional or extra help
- Specialized school outside of district
- Home schooled
- Participation in Birth – 3 Early Intervention Program (First Steps)

Intelligence Testing

If I.Q. has been tested, what is the functional assessment?

- | | | |
|--|--|---|
| <input type="checkbox"/> Superior >130+ | <input type="checkbox"/> Mild MR 55-70 | <input type="checkbox"/> Unspecified MR |
| <input type="checkbox"/> High Average 116 -130 | <input type="checkbox"/> Moderate MR 40-54 | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Average 85-115 | <input type="checkbox"/> Severe MR 20-39 | |
| <input type="checkbox"/> Borderline 71-84 | <input type="checkbox"/> Profound MR <20 | |

Describe what tests were done and the dates and results:

Please indicate the educational program in which your child participated during his/her school* years:

School Year	Type of School		Type of Class		Any Special Services		
	Regular*	Special	Regular*	Special*	Yes	No	Type
3-5 preschool							
Kindergarten							
1 st							
2 nd							
3 rd							
4 th							
5 th							
6 th							
7 th							
8 th							
9 th							
10 th							
11 th							
12 th							

* **REGULAR** school applies to public or private schools for children without disabilities.
SPECIAL school applies to any schools intended for children with disabilities

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MEDICAL/PSYCHIATRIC HISTORY: Please list all diagnoses or illnesses for your child (use an additional page if needed)

Diagnosis/Illness	Age	Date - year	Professional who made diagnosis

MEDICAL/PSYCHIATRIC HISTORY CONT.

List all hospitalizations for your child, include overnight stays (medical or psychiatric)

Reason for hospitalization	Age	Length of stay
1)		
2)		
3)		
4)		

List all surgeries for your child:

Reason for surgery	Age	Date - year
1)		
2)		
3)		

Therapy History	Age	Date - year

IMMUNIZATIONS

Up to date	Y / N / UK
Given on time	Y / N / UK

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ALLERGIC HISTORY

if yes, please describe type and the symptoms (rash, vomiting, etc)

Medications	Y / N / UK	Type: _____ Symptom(s): _____
Food	Y / N / UK	Type: _____ Symptom(s): _____
Environmental (eg. Pollen, dust, etc.)	Y / N / UK	Type: _____ Symptom(s): _____

CURRENT MEDICATIONS/SUPPLEMENTS

Medication	Dosage	Age when started	Reason for medication	Making an improvement?	
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No

Details:

REVIEW OF HEALTH SYSTEMS

Circle Yes or No for concerns NOW or in the PAST

Dental Problems	YES	NO	Kidney/Urinary/Genital Problems	YES	NO
Does your child see a dentist	YES	NO	Chronic Ear infections	YES	NO
Birth defects	YES	NO	Long term use of antibiotics	YES	NO
Heart Problems	YES	NO	Easy bruising/bleeding/anemia	YES	NO
Lung problems	YES	NO	Endocrine Problems (eg. thyroid)	YES	NO
Constipation	YES	NO	Skeletal/Bone problems (eg. scoliosis)	YES	NO
Diarrhea	YES	NO	Accidents	YES	NO
Nausea/vomiting	YES	NO	Skin problems (rash, eczema)	YES	NO
Stomach ache/pain/reflux	YES	NO			

If yes, please explain:

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NEUROLOGICAL SYSTEMS: Does your child have any of the following?

Tic Disorder/Tourette	YES	NO	Attention Deficit Hyperactivity Disorder (ADHD)	YES	NO
Tremors	YES	NO	Migraines/headaches	YES	NO
Hypotonia (low muscle tone/ floppy)	YES	NO	Toe Walking (After age 2 or persistent > 6 months)	YES	NO
Hypertonia (tight muscle tone)	YES	NO	Staring Spells	YES	NO

What hand does your child use? **Left / Right / Ambidextrous (both) / UK** Mother: **L / R**, Father: **L / R**

Hearing problems **Y / N / UK**

If Yes, sensorineural or conductive? _____

Uses hearing aid? **Y / N / UK**

Sound over sensitivity? **Y / N / UK**

Sound under sensitivity? **Y / N / UK**

Explain: _____

Explain: _____

Vision/eye problems **Y / N / UK**

If Yes, what? _____

Correctable? **Y / N / UK**

Glasses? **Y / N / UK**

Contact Lenses? **Y / N / UK**

Does your child have seizures? **Y / N / UK**

If Yes, please check the type of seizures

Febrile (Fever) Grand mal (rhythmic jerking) Petit mal/Absence

Myoclonic Complex partial Unknown

Please explain: _____

Has your child had any of the following laboratory tests?

Results:

		Normal	Abnormal	Unknown
To check for anemia	Y / N / UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lead Blood Level	Y / N / UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chromosomal Microarray	Y / N / UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Karyotype (chromosome study)	Y / N / UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fragile X DNA	Y / N / UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rett syndrome DNA (MECP2)	Y / N / UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plasma Amino Acids	Y / N / UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine for Organic Acids	Y / N / UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MRI of the brain	Y / N / UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EEG/Video Telemetry	Y / N / UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Study	Y / N / UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Audiologic (hearing) testing	Y / N / UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain stem audio evoked response (BAER/ABR)	Y / N / UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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ABUSE HISTORY

Y / N - if no please skip to next section

Was your child "traumatized" in any way? Please explain.

RESOURCES

Are you or your child receiving services from the following agencies? Check all that are appropriate.

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Regional Center | <input type="checkbox"/> Counseling | <input type="checkbox"/> Behavior Therapy/ABA |
| <input type="checkbox"/> Department of Mental Health | <input type="checkbox"/> Cal Works | <input type="checkbox"/> Speech Language Therapy (SLT) |
| <input type="checkbox"/> Division of Family Services (DFS) | <input type="checkbox"/> Cal Fresh | <input type="checkbox"/> Physical Therapy (PT) |
| <input type="checkbox"/> Child Protective Services (CPS) | <input type="checkbox"/> WIC | <input type="checkbox"/> Occupational Therapy (OT) |
| <input type="checkbox"/> SSI | <input type="checkbox"/> Food Access | <input type="checkbox"/> Psychiatric Services |
| <input type="checkbox"/> Other _____ | | |

Do you have medical insurance? Type: _____

Please bring reports!

SOCIAL HISTORY:

Child lives with:

- | | | |
|--|--|--|
| <input type="checkbox"/> both biological parents | <input type="checkbox"/> biological mother | <input type="checkbox"/> biological father |
| <input type="checkbox"/> adoptive parent(s) | <input type="checkbox"/> foster parent(s) | <input type="checkbox"/> live independently |
| <input type="checkbox"/> grandparent(s) | <input type="checkbox"/> group home | <input type="checkbox"/> residential school/treatment facility |

If adopted, at what age was adoption? _____

If foster care, provide name and address of social worker and agency supervising placement: _____

Please list all the people who live with child

Name	Age	Relationship to child

Are biological parents (*circle one*) – Married / Divorced / Separated / Never Married

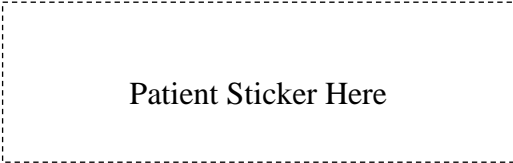
If not living with both biological parents, please specify visitation arrangement:

- Biological Mother: N/A No contact Every other weekend Other: _____
- Biological Father: N/A No contact Every other weekend Other: _____

If parents are separated or divorced: What are the custody arrangements?

- Biological Mother: N/A Joint Custody Sole Custody Other: _____
- Biological Father: N/A Joint Custody Sole Custody Other: _____

Any significant losses? _____



Household Annual Income:

\$0-24,999 \$25-49,999 \$50-74,999 \$75-99,999 \$100,000+ Unknown Decline to State

Number of people dependent on income: _____ Unknown

Is housing a problem? _____

PRIMARY CAREGIVER: Mother Father Other _____

Place of employment: _____ Job title: _____

Major Job duties/responsibilities: _____

Level of school completed: # years of school completed _____

- Less than 7-8th grade
- 7-8th grade school
- Partial high school
- High school graduate or GED
- Partial college or specialized training (Associate's Degree)
- Standard college or university graduation (Bachelor's Degree)
- Graduate professional training (Graduate degree)

ADDITIONAL CAREGIVER: Mother Father Other _____

N/A – No Additional Caregiver

Place of employment: _____ Job title: _____

Major job duties/responsibilities: _____

Level of school completed: # years of school completed _____

- Less than 7-8th grade
- 7-8th grade school
- Partial high school
- High school graduate or GED
- Partial college or specialized training (Associate's Degree)
- Standard college or university graduation (Bachelor's Degree)
- Graduate professional training (Graduate degree)

FAMILY HISTORY

Ethnicity of child: Hispanic or Latino Origin? **Y / N**

Ethnicity of child: (please select one)

- American Indian or Alaskan Native
- Asian _____
- Pacific Islander
- Black/African American
- Hispanic or Latino
- White/Caucasian
- Other _____
- More than one of the ethnicities listed
- Do not know
- Decline to answer

Primary Language Spoken in the Home: _____ Second Language: _____

MOTHER'S name (biological) _____ Height _____

Address: _____

Street City State Zip

Hispanic or Latino Origin? **Y / N**, Age _____ Birthdate ____/____/____ Birthplace _____

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Ethnicity: *(please select one)*

- | | |
|--|--|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> White/Caucasian |
| <input type="checkbox"/> Asian _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Pacific Islander | <input type="checkbox"/> More than one of the ethnicities listed |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Decline to answer |

General health (major illnesses, hospitalizations, surgeries, medications, mental health concerns, educational problems)

FATHER'S name (biological) _____ Height _____

Address: _____
Street
City
State
Zip

Hispanic or Latino Origin? **Y / N**, Age _____ Birthdate ____/____/____ Birthplace _____

Ethnicity: *(please select one)*

- | | |
|--|--|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> White/Caucasian |
| <input type="checkbox"/> Asian _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Pacific Islander | <input type="checkbox"/> More than one of the ethnicities listed |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Decline to answer |

General health (major illnesses, hospitalizations, surgeries, medications, mental health concerns)

SIBLINGS/OTHER PREGNANCIES *Include any miscarriages, stillbirths, or babies that died*

Name of sibling	Sex (M/F)	Age	Date of Birth	Different Father?	Different Mother?	List any health/behavior/ learning problems	Lives with your child?
				Yes / No	Yes / No		Yes / No
				Yes / No	Yes / No		Yes / No
				Yes / No	Yes / No		Yes / No
				Yes / No	Yes / No		Yes / No
				Yes / No	Yes / No		Yes / No
				Yes / No	Yes / No		Yes / No
				Yes / No	Yes / No		Yes / No

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Are there plans for future pregnancies? **Y / N / UK**

Has anyone in the family died at an early age (younger than 45) from sudden death? **Y / N / UK**

Does anyone in the family have a heart defect, murmur or unusual heart beat? **Y / N / UK** Age: _____

Does anyone in the family have chest pain on exertion? **Y / N / UK**

Comments:

EXTENDED FAMILY HISTORY

Please list any family member with a history of any of the conditions listed below. Indicate how the family member is **related to the patient** (see guide below):

Relative/Family Member List:

Mother/Father/Sister/Brother/Twin/Half Sister/Half Brother

Maternal: *Mom's Mom/ Mom's Dad/ Mom's Brother/ Mom's Sister/ Mom's Grandmother/ Mom's Grandfather/ Mom's Uncle/ Mom's Aunt/ Mom's Cousin*

Paternal: *Dad's Mom/ Dad's Dad/ Dad's Brother/ Dad's Sister/ Dad's Grandmother /Dad's Grandfather/ Dad's Uncle/ Dad's Aunt/ Dad's Cousin*

CONDITION/DISORDER

RELATIVE (Relation To Patient)

1. Autism Spectrum Disorder: _____
2. Fragile X syndrome: _____
3. Tuberous sclerosis: _____
4. Other genetic disorders: _____
5. Intellectual disability/Mental Retardation: _____
6. Learning disability: _____
7. Language disorder (*ex Speech Therapy/late talker/stutter*): _____
8. Attention deficit hyperactivity disorder (ADHD): _____
9. Tourette's syndrome (tics): _____
10. Seizure disorder (epilepsy): _____
11. Obsessive compulsive disorder: _____
12. Anxiety disorders: _____
13. Depression: _____
14. Bipolar disorder: _____
15. Schizophrenia: _____
16. Alcoholism: _____
17. Drug addiction: _____
18. Miscarriages or still births (*in the family*): _____
19. Childhood deaths: _____
20. Birth defects (*ex. cleft lip, club foot, heart defect*): _____
21. Chromosome disorders: _____
22. Abnormal physical features (*ex big head, abnormal fingers, face*): _____
23. Gland/endocrine(*ex thyroid, diabetes, delayed puberty*): _____
24. Immune disorders (*ex arthritis, lupus, fibromyalgia*): _____
25. Anything that runs in family?: _____

