

# The Iditaform --- Medical & Developmental History

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Child's name: \_\_\_\_\_  
Last First Middle

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## 1. PREGNANCY HISTORY

- A. Length of pregnancy: \_\_\_\_\_ B. Weight gain: \_\_\_\_\_
- C. List any prescribed or over the counter medications taken during pregnancy (include vitamins): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- D. Were cigarettes, alcohol or other drugs used during pregnancy? If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
- E. At what month did you first feel your baby move? \_\_\_\_\_ months  
Please check one: Baby was . . . \_\_\_\_ quiet \_\_\_\_ active \_\_\_\_ very active  
As the pregnancy progressed, were there any changes in your baby's activity level? If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
- F. List "other" concerns you had during pregnancy: \_\_\_\_\_  
\_\_\_\_\_
- G. Previous pregnancies: Number of pregnancies \_\_\_\_\_ Number of children living \_\_\_\_\_  
Were there any difficulties during previous pregnancies? Yes \_\_\_\_ No \_\_\_\_  
If yes, describe: \_\_\_\_\_

## 2. LABOR / DELIVERY

- A. How was your labor? \_\_\_\_ Uncomplicated \_\_\_\_ Difficult  
Please describe only if difficult: \_\_\_\_\_  
\_\_\_\_\_
- Was baby monitored with internal fetal monitor during labor? Yes \_\_\_\_ No \_\_\_\_
- Did membranes rupture? Yes \_\_\_\_ No \_\_\_\_ Number of hours prior to delivery: \_\_\_\_\_
- Were you awake during the delivery? Yes \_\_\_\_ No \_\_\_\_
- Labor was . . . Spontaneous \_\_\_\_\_ Induced \_\_\_\_\_
- Anesthesia used: Yes \_\_\_\_ No \_\_\_\_ If yes, type: \_\_\_\_\_
- Type of birth? Vaginal: Head first \_\_\_\_ Breech \_\_\_\_  
Were forceps used? Yes \_\_\_\_ No \_\_\_\_ Unknown  
Cesarean Section: If yes, describe reason: \_\_\_\_\_
- Please check one: Baby was born . . . full-term \_\_\_\_ late \_\_\_\_  
premature \_\_\_\_ # of weeks: \_\_\_\_\_

**3. BIRTH / EARLY INFANCY**

- A. Birth weight: \_\_\_\_\_ Length: \_\_\_\_\_ Head circumference: \_\_\_\_\_
  - B. Apgar score at 1 minute: \_\_\_\_\_ 5 minutes: \_\_\_\_\_
  - C. Describe any difficulties with the baby immediately after birth: \_\_\_\_\_  
\_\_\_\_\_
  - D. Did baby cry immediately? Yes \_\_\_ No \_\_\_  
Did baby need help with breathing? Yes \_\_\_ No \_\_\_ How long? \_\_\_\_\_
  - E. How long was baby in hospital? \_\_\_\_\_ days or \_\_\_\_\_ months  
Did the baby spend time in the NICU (neonatal intensive care unit)? Yes \_\_\_ No \_\_\_  
If yes, how long? \_\_\_\_\_ days and/or \_\_\_\_\_ months
  - F. Was medication prescribed for the baby? Yes \_\_\_ No \_\_\_ If yes, describe reason: \_\_\_\_\_  
\_\_\_\_\_
  - G. While in the hospital, did the baby require special care after birth (e.g. therapy, evaluation by a specialist)? Yes \_\_\_ No \_\_\_ If yes, describe reason: \_\_\_\_\_  
\_\_\_\_\_
  - H. Were there any difficulties during the baby's first months? If yes, please check and describe:  
 \_\_\_\_\_ feeding                  \_\_\_\_\_ sleeping                  \_\_\_\_\_ alertness                  \_\_\_\_\_ activity level  
 \_\_\_\_\_ movement                  \_\_\_\_\_ jaundice                  \_\_\_\_\_ Other: \_\_\_\_\_
- Describe: \_\_\_\_\_

**4. CHILD'S HEALTH HISTORY**

- A. Has your child had any serious illnesses, accidents, surgeries or broken bones? (also include any poisonous substance your child has ingested):

Date	Description	If hospitalized, give name & location

- B. Has your child had x-rays or special x-rays such as: CAT Scan \_\_\_\_\_ MRI \_\_\_\_\_  
Other: \_\_\_\_\_
- C. Has your child had any recurrent illnesses? If yes, please describe:  
\_\_\_\_\_

D. Has your child had any of the following illnesses? If yes, at what age?

	Age		Age		Age
Chicken Pox		German Measles		Hepatitis	
Mumps		Whooping Cough		Meningitis	
Measles		CMV		Other:	

E. Has your child had difficulty with any of the following: If yes, at what age?

	Age		Age		Age
Skin (rashes)		Anemia		Diarrhea	
Speech		Breath holding spell		Coordination	
Swallowing		Turns blue		Frequent falling	
Sucking		Respiratory problems		Staring spells	
Vomiting		Asthma		Fainting spells	
Dental		Heart		Ear Infections	
Allergies		Special dietary considerations		Feeding	
Constipation		Other:		Other:	

Is your child allergic to any medication, foods or substances? Yes \_\_\_ No \_\_\_

If yes, describe: \_\_\_\_\_  
 \_\_\_\_\_

Has your child had any other medical problems which you believe are related to your present concerns about your child? Yes \_\_\_ No \_\_\_

If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

Do you have any concerns regarding your child' s hearing or vision? Yes\_\_\_ No \_\_\_\_\_

If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

Has your child seen a vision specialist? Yes \_\_\_ No \_\_\_\_\_

If yes, give doctor' s name and reason for visit: \_\_\_\_\_  
 \_\_\_\_\_

Has your child seen an ear specialist? Yes \_\_\_ No \_\_\_\_\_

If yes, give doctor' s name and reason for visit: \_\_\_\_\_  
 \_\_\_\_\_

Has your child had a hearing test? Yes \_\_\_ No \_\_\_\_\_

If yes, give reason for visit: \_\_\_\_\_  
 \_\_\_\_\_

G. Check if child wears or has worn the following: If yes, at what age?

	<b>Age</b>		<b>Age</b>
Glasses		Hearing aids	
Corrective Shoes		Braces/Splints	
Artificial Devices		Describe:	

H. Is your child taking any ongoing medication?

Medication	Purpose / Condition	Date	Dosage	Times per day	How long on medication?
<b>Describe any side effects:</b>					

**PLEASE BRING IMMUNIZATION RECORD TO INITIAL MEDICAL & SCHOOL VISITS.**

**\*\*\* Shot record may be kept in plastic sheet protector. \*\*\***

**5. FAMILY MEDICAL HISTORY**

A. Check any conditions present in child's biological family: (If checked, please explain:)

	<b>Mother</b>	<b>Mother' s Family</b>	<b>Father</b>	<b>Father' s Family</b>
Birth defects	_____	_____	_____	_____
Inherited disorder	_____	_____	_____	_____
Infant deaths	_____	_____	_____	_____
Learning Problems	_____	_____	_____	_____
Mental retardation	_____	_____	_____	_____
Muscle disease/weakness	_____	_____	_____	_____
Neurological disease	_____	_____	_____	_____
Substance Abuse	_____	_____	_____	_____
Mental illness	_____	_____	_____	_____
Vision/Hearing disorder	_____	_____	_____	_____
Epilepsy/Seizures	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Behavior or Emotional disorders	_____	_____	_____	_____
Other health problems	_____	_____	_____	_____

B. Does any other family member have difficulties similar to your child's? If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**6. CHILD'S DEVELOPMENT / BEHAVIOR**

A. **Developmental Milestones**

<b>At what age did your child first:</b>	<b>Age</b>	<b>N/A</b>
Hold head steady when being carried		
Roll from back to tummy		
Sit alone		
Crawl on hands and knees		
Pull to stand		
Walk holding on to things		
Walk alone		
Drink from a cup		
Respond to name		
Say first word		
Feed self with fingers		
Use a spoon		
Speak with 3 or more word phrases		
Toilet train		

**B. Communication**

How does your child communicate his/her needs to you? \_\_\_\_\_  
 \_\_\_\_\_

Do you still do much detective work to understand your child' s needs? Yes \_\_\_\_ No \_\_\_\_

Is your child easily understood? \_\_\_\_\_

When you speak to your child does s/he pay attention? Yes \_\_\_\_ No \_\_\_\_

When you speak to your child does s/he understand you? Yes \_\_\_\_ No \_\_\_\_

**C. Feeding**

Do you have concerns about your child' s feeding or eating behavior? If yes, describe:

Has your child had any recent weight gains or losses? If yes, describe: \_\_\_\_\_  
 \_\_\_\_\_

What types of food does your child eat? \_\_\_\_\_ Pureed \_\_\_\_\_ Finely chopped  
 \_\_\_\_\_ Regular

**D. Self Help**

Is your child able to:

dress  
 undress  
 use the toilet

No	Yes	Yes With Help

**E. Social Skills**

Does your child get along with other children and adults? Yes \_\_\_\_ No \_\_\_\_

Who does your child prefer to play with? \_\_\_\_\_ Family only \_\_\_\_\_ Older children \_\_\_\_\_ Alone  
 \_\_\_\_\_ Same age \_\_\_\_\_ Younger children

What are your child' s favorite play activities? \_\_\_\_\_  
 \_\_\_\_\_

Are there any unusual or repetitive play activities? \_\_\_\_\_  
 \_\_\_\_\_

Does your child use both hands to pick up and play with toys? \_\_\_\_\_  
 \_\_\_\_\_

Does your child enjoy school? (Describe) \_\_\_\_\_  
 \_\_\_\_\_

Is your child involved in any recreational activities? (Describe) \_\_\_\_\_  
 \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_

**F. Behavior (Describe your child's behavior by checking the frequency)**

	rarely	sometimes	often		rarely	sometimes	often
Happy				Cooperative			
Sad				Affectionate			
Angry				Hyperactive			
Shy				Aggressive			
Restless				Indifferent			
Temper				Cries often			
Stubborn				Withdrawn			
Immature				Plays alone			
Jealous				Plays with other children			
Tantrums				Difficult to discipline			
Rocking				Not afraid of strangers			
Sleep problems				Poor attention / distractible			
Activity level: low or high				Unusual fears or routines			
Does not want to leave parent				Other:			

Please circle behaviors that concern you in the chart above and describe here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**G. Do you have concerns regarding any of the following behaviors? (Please circle)**

Impulsiveness

Safety Concerns (Street, water, house safety issues)

Stealing

Acting out sexual behaviors

Substance Abuse

Other Behaviors: \_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

**7. SERVICES**

Please list the names of the programs and people that have worked or are working with your child:

Service	Name of Program	Name of Teacher / Provider / Therapist	Date(s)
Pediatrician / Doctor			
Child Care Program			
Infant Learning Program			
Head Start Program			
Preschool Program			
Public Health Nurse			
Occupational Therapist			
Physical Therapist			
Speech Therapist			
DFYS / Child Protection Services -- Caseworker			
Other:			
Other:			

Has your child or family needed other services to assist in your child' s best development?

Please check and briefly comment if you have or need these services.

<b>Have</b>	<b>Need</b>	
_____	_____	Behavior assessment / Counseling
_____	_____	Respite Care
_____	_____	Parenting information / Assistance
_____	_____	Parent/sibling emotional support
_____	_____	Nutrition
_____	_____	Recreational activities
_____	_____	Financial support for required services
_____	_____	Other: _____

Comment: \_\_\_\_\_

If you needed assistance with your child, who would be there to help you? \_\_\_\_\_

**8. RESOURCES / CONCERNS**

Please take a few minutes and think about and share the following:

My child is good at: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have concerns about: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child had previous evaluation(s) or services to address your concerns? Yes \_\_\_\_ No \_\_\_\_  
If yes, please explain (by whom, dates, results, recommendations, etc.).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**9. FAMILY INFORMATION**

A. Parent(s) / Caregivers living with this child: \_\_\_\_\_  
\_\_\_\_\_

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

What is your relationship to this child? (please circle)

Birth Parent    Adoptive Parent    Foster Parent    Step Parent    Other: \_\_\_\_\_

How long has this child lived with you? \_\_\_\_\_

Occupation: \_\_\_\_\_

Last grade completed in school: \_\_\_\_\_ Marital status: \_\_\_\_\_

Any physical learning or emotional problems we should be aware of?

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

What is your relationship to this child? (please circle)

Birth Parent    Adoptive Parent    Foster Parent    Step Parent    Other: \_\_\_\_\_

How long has this child lived with you? \_\_\_\_\_

Occupation: \_\_\_\_\_

Last grade completed in school: \_\_\_\_\_ Marital status: \_\_\_\_\_

Any physical learning or emotional problems we should be aware of? \_\_\_\_\_  
\_\_\_\_\_

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Please list all other adults and children living in the household with this child:

Name	Birthdate	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If the child is **not living with his/her biological family**, please complete as much of the following information as possible about the child's birth parents:

**Birth Mother**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Occupation: \_\_\_\_\_

Last grade completed in school: \_\_\_\_\_ Marital status: \_\_\_\_\_

Any physical learning or emotional problems we should be aware of? \_\_\_\_\_

**Birth Father**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Occupation: \_\_\_\_\_

Last grade completed in school: \_\_\_\_\_ Marital status: \_\_\_\_\_

Any physical learning or emotional problems we should be aware of? \_\_\_\_\_

Please list all biological siblings (full and half) of this child:

Name	Birthdate	Relationship to Child	Place of Residence
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any problems with this child's siblings we should be aware of? \_\_\_\_\_

\_\_\_\_\_