Therapedia #:_____

**Birth History**

| | | |
|---|---|---|
| ( ) Full term<br>( ) Premature | If premature, give:<br>Month_____<br>Weight_____ | ( ) Vaginal birth<br>( ) Cesarean birth |
| Was labor:<br>( ) prolonged<br>( ) short<br>( ) within normal range<br>APGAR score, if known_____ | Were forceps used? Yes<br>Medication during delivery:<br>_____<br>_____<br>Time in NICU?_____<br>Time on ventilator/oxygen_____<br>_____ | Were there other complications such as:<br>( ) breathing difficulty<br>( ) jaundice<br>( ) tube fed<br>( ) feeding difficulty<br>( ) incubation<br>( ) transfusion<br>( ) congenital defects |

Was your child breast-fed? Yes If yes, how many weeks/months?_____

Did your child have difficulty breast feeding? Yes If yes, explain_____

Did your child have difficulty using the bottle? Yes If yes, explain_____

**Medical History**

Has your child had any of the following? If yes, give dates.

Meningitis_____ High temperatures _____ Seizures_____

Ear infections_____ _____

Allergies: ( ) latex ( )food - specify_____ ( ) other – specify_____

Physical Injuries (describe and date)_____

_____

Surgeries/Medical Procedures (describe and date)_____

_____

Hospitalizations (describe and date)_____

_____

Medical diagnoses such as diabetes, epilepsy, heart trouble, autism, ADHD_____

Is your child currently on medication? Yes Please list and state for which problem

_____

Is your child currently on supplements, holistic care, over the counter medications, etc?

_____

Has your child had a hearing test? Yes Results_____

Does your child wear glasses? Yes Has he/she had an eye exam? Yes Results_____

Does your child wet the bed after 3 years of age?_____

Does your child have trouble learning urinary control?_____

Does your child have trouble learning bowel control?_____

Other medical history_____

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