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Patient Information Form

Reason for Referral:

- Gifted
 - Other (Please explain): _____
-

Student's Name: _____ **Nickname:** _____

Age: _____ **Date of Birth:** _____ **Sex:** () Male () Female

Primary Language _____ **Other Languages** _____

Place of Birth: _____

If not born in Florida, when did child move to Florida? _____

Mother's Name: _____ **Age:** _____

Home Address: _____

City/State/Zip: _____

Occupation: _____ **Education** _____

Place of Employment: _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Fax Number:** _____

E-mail Address: _____

Mother's age at the time of child's birth: _____

Father's Name: _____ Age: _____

Home Address: _____

City/State/Zip: _____

Occupation: _____ Education: _____

Place of Employment: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Fax Number: _____

E-mail Address: _____

Father's age at the time of child's birth: _____

Parents are: () Married () Divorced () Separated () Widowed () Single

How long married? _____ How long separated/divorced? _____

How long widowed? _____ Child's age at separation, divorce or death? _____

If parents are divorced, what is the custody arrangement? _____

Siblings (Including half-siblings and step-siblings and note as such)

<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>School/Grade</u>	<u>Living at home (Y/N)</u>

Others living in the home? Yes () No () If yes, please complete below.

Relationship: _____ Age: _____

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Birth and Developmental History

Pregnancy and Delivery

Length of pregnancy: _____

Were there any complications during pregnancy? () Yes () No

If so, please explain: _____

Type of Delivery: () Caesarian () Vaginal Birth Weight: _____

Please describe your child's health during and after delivery. _____

Please describe your child's temperament as an infant. _____

Developmental Milestones (Please give approximate ages):

Age sat up: _____ Age crawled: _____ Age walked: _____

Age spoke first word: _____ Age spoke in sentences: _____

Age potty trained at day: _____ Age potty trained at night: _____

Please indicate any areas of concern for your child:

_____ Eating _____ Sleeping _____ Nightmares _____ Nail biting

_____ Getting along with peers _____ Impulsivity _____ Paying attention

Medical History

The child's current health is: () Excellent () Good () Fair () Poor

Please indicate if your child has suffered from any of the following:

___ Head Injury – If so, was there any loss of consciousness? No ___ Yes ___

___ Seizures ___ Chronic Ear Infections ___ Asthma

___ History of acute or chronic illness of any kind. If yes, please describe: _____

Has your child ever been taken to the emergency room, hospitalized or had outpatient surgery since birth? () Yes () No

If yes, please describe the incident, treatment and age when incident occurred.

Is your child currently taking medication or has he/she ever taken medication?

Yes () No ()

If yes, please include name of medication, how long it has been prescribe and the reason for taking medication.

Name of physician prescribing medication _____

Screening/evaluation for hearing? If so, date of most recent exam and results: _____

Screening/evaluation for vision? If so, date of most recent exam and results: _____

Has your child ever received speech/language therapy, occupational, and/or physical therapy? If so, please specify dates, reason for therapy, and therapist.

Educational History

Age child began daycare, nursery, or preschool _____

Please list all of the schools your child has attended (including preschool/daycare):

Name	City	Grade(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current School: _____

Grade: _____ Name of Teacher: _____

School's Phone Number: _____

Teacher's E-mail address: _____

Zoned Elementary School: _____

Zoned School for Gifted program: _____

Social Relationships and Activities

Does your child interact appropriately with peers and/or siblings? If not, please explain.

What activities does your child participate in and/or what hobbies does he/she enjoy?

Who may we thank for referring you? _____