

**Client's Name:**

**DOB:**

What Services are you interested in?

### **EARLY DEVELOPMENTAL HISTORY**

#### **PREGNANCY, BIRTH, EARLY DEVELOPMENT:**

Was the birth full term    Yes    No

Length of pregnancy?

Birth Weight

List ages that the following occurred (or indicate a N/A):

Sat Independently:

Took First Step:

Walked Independently:

Spoke single words:

Spoke 2-3 words:

Fully Toilet Trained:

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Describe any developmental delays in language, motor, social skills, or behavior concerns observed before age 3:

### **MEDICAL HISTORY**

Check (✓) all that apply:

Balance Problems

Emotional Problems

High Fevers

Medication

Mental illness	Head Injuries	Vision Difficulties	Accidents
Convulsions	Seizures	Diabetes	Asthma
Ear Infections	Allergies	Measles	Glasses
Frequent Headaches	Hearing Problems	Chicken pox	Nausea
Tiredness/Weakness	Memory Difficulties	Stomach Problems	Eczema

**DIAGNOSTIC INFORMATION:** Please list any medical diagnoses along with the physician/psychologist information and date:

**HEARING/VISION:** Has your child had a recent vision and hearing screening completed?

Y N

If so, what were the dates of evaluation and results?

**ALLERGIES/DIET:** Please list any allergies your child may have?  
Does your child have any dietary restrictions or special diet?

**MEDICATIONS:** Please list any medications with dosage and reason your child is currently taking:

*NOTE: An "Authorization to Administer Medication" form must be on file in order for Pathways to administer any medication in our clinic setting*

## **SCHOOL & EDUCATION HISTORY**

**CURRENT SCHOOL:**

**GRADE:**

**TEACHER:**

**DAYS/TIMES:**

List previous school(s) attended with dates since Preschool and/or Kindergarten:

Check (✓) all that apply to student:

Speech/Language therapy

Occupational therapy

Physical therapy

Retained

Evaluated/Tested

Enjoys school

Sports

Short Attention Span

Attendance

Physical Limitations

Anger Problems

Easily Frustrated

Mental Illness

Behavior Problems

OSS/ISS

Aggressive/Fights

Counseling

Academic Difficulties (list subject areas):

Please explain any of the above checked items:

Additional services or therapies (with dates and times):

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**BEHAVIOR CHECKLIST**

Please check the behaviors that best describe your child:

Feels happy with him/herself

Very compliant

Generally happy

Sucks thumb

Jealous of siblings

Does not listen well

Demands excessive attention

Overly dependent on others

Wets the bed

Plays well with other children	Overly anxious to please	Cries often
Exhibits uncooperative attitude	Tries to control others	Poor self-control
Has very few close friends	Relates well with adults	Friendly
Lacks motivation, lazy	Aggressive	Sad or depressed
Does not adjust to change	Fearful	Shy, withdrawn
Easily frustrated	Loud	Can be trusted
Acts younger than age	Affectionate to family	Daydreams often
Restless	Ritualistic/repetitive behaviors	Difficulty sleeping

Please explain any of the above checked items:

**POSITIVE STRATEGIES:**

My child responds to:

Praise	Edible reinforcers	Receiving an item
Getting time to do a favorite activity	Attention from other children	Token economy system
Alone time	Getting breaks	Movement activities

Positive strategies used in the home (please describe):

Effectiveness of positive strategies:

Behavior improves	Behavior stays the same	Behavior worsens
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**DISCIPLINE AT HOME:**

Child is disciplined (check one):

Frequently	Occasionally	Rarely
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What type of discipline is used?

Spanking

Loss of privileges

Restricted

Isolated

Reactions to discipline:

Becomes angry

Cries

Withdraws

Effectiveness of discipline:

Behavior improves

Behavior stays the same

Behavior worsens

### **PREFERRED ACTIVITIES AND INTERESTS**

Favorite activities:

Favorite toys/games:

Favorite places to go:

Favorite foods/treats:

Favorite characters:

Favorite TV shows/movies:

Other:

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### **ADDITIONAL INFORMATION**

Please share your child's strengths:

Please share any additional areas of need or concerns:

In what areas/skills would you like parent training and support?

If center location, please choose:

- *Please remember to include a copy of the most recent IEP, IFSP, ISP, psychological evaluation or other pertinent information.*