Progressive Community
Care Center

Client Name		Chart Number	

MEDICAL/DEVELOPMENTAL HISTORY S4D3

A. PREGNANCY AND BIRTH

Is your child: □ biological child □ adopted child □ foster child □ other:

Mother's age at birth? ________ Did mother receive routine medical prenatal care? □Yes □ No

Please specify any medications used during pregnancy and the reason used: ______________________________

____

____

Pregnancy lasted ______________weeks / months Child's birth weight: ______pounds _____ounces

APGAR score …at 1 minute_____ …at 5 minutes_____ □ Unsure / Don't know

Did child go home from the hospital at the same time as the mother? □Yes □ No If not, explain why: ______________

____

____

____

Pregnancy lasted ______________weeks / months Child's birth weight: ______pounds _____ounces

APGAR score …at 1 minute_____ …at 5 minutes_____ □ Unsure / Don't know

Please check the conditions below that describe the health of the child and mother during…

Mothers pregnancy	Child's Delivery	Child's Condition at Birth
□ No complications	□ Normal	□ Normal
□ Blackouts	□ Induced labor	□ Lack of oxygen
□ Falls	□ C-section	□ Breathing problem
□ Physical injury	□ Breech birth	□ Birth injury/defect
□ Excessive bleeding	□ Unusually long labor (>12 hours)	□ Jaundice
□ Hypertension	□ Premature # of weeks	□ Newborn ICU # days
□ Diabetes	□ Overdue # of weeks	□ Other problem (specify)
□ Emotional stress	□ Other problem (specify)	
□ Toxemia		
□ Alcohol and/or drug use		
□ Use of tobacco		

Please specify any medications used during pregnancy and the reason used: ______________________________

____

B. HEALTH

Describe the state of your child's current health: □ Excellent □ Good □ Fair □ Poor

Is your child currently taking any medication? □Yes □ No

If yes, please list medications and uses: ______________________________

____

____

Has your child ever been identified as having a disability? □Yes □ No

If so, by whom, what age, & what disability? ______________________________

____

Has your child ever received psychological counseling? □Yes □ No

If so, by whom (professional/agency) and when: ______________________________

____

Has your child ever had therapy services from a private entity? (i.e., speech, occupational, physical, vision)? □Yes □ No

If so, by whom (professional/agency) and when: ______________________________

____

Has your child ever had educational services from a private entity (i.e., private tutor, Sylvan Learning)? □Yes □ No

If so, by whom (professional/agency) and when: ______________________________

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Has your child ever participated in an early intervention program? □Yes □ No
If so, by whom (professional/agency) and when: ______________________

____

Medical History	
Has your child had any of the following? Please check all that apply.	Please describe and give details, dates, and/or age of onset
□ Serious Illnesses	
□ Head Injuries	
□ Seizures or convulsions	
□ Surgery/Hospitalization	
□ History of Ear Infections	
□ Allergies and/or Asthma	
□ Vision Problems	
□ Hearing Problems	
□ Frequent Nightmares and/or Bedwetting	
□ Other health problem	
Family History	
Is there a ***family history*** for the following problems?	*Biological* family member with the history (parent, sister/brother, aunt/uncle, grandparent, 1st cousin, etc.)
□ Learning Difficulties (reading, math, writing, spelling)	
□ Speech or Language problem (articulation, stuttering, etc.)	
□ Developmental Disorder (such as Autism, Asperger's disorder, etc.)	
□ Emotional Problems (depression, excessive anxiety, mood swings, etc.)	
□ Intellectual Disability	
□ School Failure (failing grades, dropout, etc)	
□ Drug or Alcohol Addiction	

C. DEVELOPMENT

Please indicate the age or range when your child performed the following milestones (check 1 box per row):								
Milestone	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	Other (specify age)
Sat up without help								
Crawled								
Walked alone								
Walked up Stairs								
Spoke first words								
Spoke short phrases								
Spoke in sentences								
Fully bladder trained								
Fully bowel trained								
Stayed dry all night								

PCCC Staff Name, Title (Print) ______________________
PCCC Staff Signature ______________________ **Date** ______________________