SUPPLEMENTAL HISTORY FORM FOR CHILDREN

Child's Name _____ Date of Birth _____
Address _____ Today's Date _____
_____
Parent's Name _____

PLEASE FILL IN AS COMPLETELY AS POSSIBLE:

Please describe your child's difficulty:

When did you first notice this or when did the child first complain about it?

Was there any illness or injury just before this began?

Has anyone ever tested your child for this problem or given you a name for the condition? (When, who, what was said)

Was any treatment suggested? When? What were the results?

Were any medications or drugs used by this child's mother during pregnancy?

Any serious illness of mother during pregnancy?

How was your child's birth? Was there any difficulty during delivery for mother or child?

Was your child breast fed? How long? Any problems?

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Did your child have infant formula? Type? Any problems?

When did your child start solid food? Cow's milk?
Any problems?

Have you ever noticed a connection between certain foods and how your child is doing? (which foods?, what reaction?)

Does your child have any very strong likes or dislikes for certain foods?
Have you noticed any reaction, better or worse, when these are eaten?

Have you ever tried eliminating any foods from your child's diet? What were the results?

Is your child left handed, right handed, both, can't tell yet?

Does your child seem well-coordinated? Any tendency to reverse numbers or letters when reading or writing?

Does your child learn things easily? Any problems you or the school have noticed? Any reading difficulties?

Has your child ever been put on Ritalin, Cylert or any medication for "hyperactivity, "attention deficit disorder," or any similar problem? Has anyone prescribed tranquilizers or other medication to change his or her behavior? (when?, what drug?, how long?, who prescribed?, what results?)

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