Medical History Questionnaire

Name: _____ Birth date: _____ Male___ Female___
Handedness: Right_____ Left_____

Birth History

Was your child born full term? Yes___ No___ If No, at how many weeks? _____

Did your child meet all of their developmental milestones? Yes___ No ____

If No, please explain_____

General Health

Does your child have any serious illness or medical condition? Yes___ No ____ Explain_____

Has your child had any surgery? _____

Does your child have any allergies to medicine, food or environment? _____

Does your child have a history of sleep disturbance?_____

Trouble falling asleep? Yes____ No____ Middle of night wakening? Yes____ No_____ Snoring? Yes___ No____

Concussion History

Has your child ever been diagnosed with a concussion or had their "bell rung" in the past? Yes___ No___

If Yes, when? _____

Was the head injury associated with loss of consciousness? Yes___ No___ If Yes, for how long?_____

Was there loss of memory for events that occurred either prior or after the injury? Yes___ No____

If Yes, for how long? _____

Did it require hospitalization? Yes____ No____ If Yes, for how long? _____

Personal History	**Yes**	**No**
Migraine		
Headaches		
Vision therapy		
ADD/ADHD		
Dyslexia		
Learning Disabilities		
Anxiety		
Depression		
Panic Attacks		
Other psychiatric disorders		
Seizure disorder/epilepsy		

Family History	**Yes**	**No**	**Who**
Migraine			
Headaches			
ADD/ADHD			
Dyslexia			
Learning Disabilities			
Anxiety			
Depression			
Panic Attacks			
Other psychiatric disorder			
Seizure disorder/ Epilepsy			