Health Profile

CHILD INFORMATION

Name _____ DOB _____Age_____

Date of Evaluation _____ Session Schedule _____ Day _____ Time _____

Pediatrician _____ Phone Number_____

Referred By _____ Phone Number _____

Emergency Contact _____ Phone Number _____

SPECIALISTS/ EVALUATIONS

☐Developmental Pediatrician _____ ☐Pediatrician_____

☐Psychiatrist _____ ☐ Psychologist _____

☐Educational Consultant _____ ☐ Behavioral Specialist_____

☐Occupational Therapist _____ ☐Physical Therapy _____

☐Speech & Language Pathologist _____ ☐Nutritionist _____

Other _____

Explain _____

GOALS & REASONS FOR COMING TO LCF KIDS

☐Gross Motor Development ☐Sensory Integration ☐Learning Disorders

☐Autism ☐ADD / ADHD ☐ Developmental delays

☐Pervasive Developmental Disorder (PDD) ☐ Other _____

Explain _____

ALLERGIES

Has your child been diagnosed with allergies? ☐ YES ☐ NO

If so, please explain _____

Does your child have any food allergies? ☐YES ☐NO

If so, please explain _____

Does your child carry an epi-pen at all times? ☐ YES ☐NO

If so, please explain _____

Please list any medications your child has an allergy to: _____

PLEASE CHECK OFF ALL MEDICAL CONDITIONS &DIAGNOSES THAT APPLY TO YOUR CHILD:

Asthma / Respiratory / Allergies / Skin

☐Asthma Diagnosis	☐ Hay Fever	☐Exercise-induced asthma
☐Chest tightness	☐ Prolong shortness of breath	☐ wheezing
☐Eczema	☐ Molluscum	☐ Other _____

Explain: _____

Neurological

☐Fainting	☐ Cerebral Palsy	☐Seizure Disorders (epilepsy)
☐Dizziness	☐ Dyspraxia	☐Concussions
☐Down Syndrome	☐ Dysphasia	☐Other _____

Explain: _____

Musculoskeletal

☐Orthopedic Condition	☐ Juvenile Rheumatoid Arthritis	☐ Dystonia
☐Joint Pain	☐Muscular Dystrophy	☐ Other _____

Endocrine

☐Juvenile Diabetes	☐ Metabolic Disorder	☐ Thyroid

☐ Other _____ Explain: _____

Gastrointestinal

☐IBS ☐Crohn's Disease ☐Reflux
☐Other _____ Explain: _____

Cardiovascular

☐Mitral Value Prolapse ☐Cardiac Myopathy ☐ Thyroid ☐
Other_____ Explain: _____

Genetic Disorders

☐Williams Syndrome ☐ Fragile X ☐ Other _____

Explain: _____

Other Related Conditions

☐Lyme disease ☐Pandas ☐Psychiatric Disorder

Please check off those areas of concern you may have for your child:

☐Listening ☐ Grossing Motor Skills ☐ Poor handwriting

☐Articulation ☐ Athletic Development ☐ Clumsiness

☐Attention ☐Coordination/ Dyspraxia ☐Difficulty cutting with Scissors

☐Following Directions ☐ Motor Planning / Apraxia ☐Difficulty with right/ left & up/ down

☐Completing Tasks ☐Visual Spatial Awareness ☐Confusion with letters & numbers

☐Impulsivity ☐ Unable to ride bike ☐Unable to tie shoes or button clothes

☐Kinesthetic Awareness (Body Space)

Explain: _____

Confidence / Social Concerns:

☐Self –Esteem ☐Motivation ☐Social Skills

Explain: _____

Behavioral Concerns:

☐Frustrations ☐Explosive personality

☐Inappropriate behaviors ☐Tendency for violence

☐Difficulty in social situations ☐Difficulty well with others

☐Others _____

Behavior Plan: _____

Do you use any incentive ☐ yes ☐ no If yes, what works: _____

Explain: _____

Health Habits / Nutrition

☐Special Diet ☐ Vitamin or mineral supplement

☐Picky eater ☐Engage in regular exercise

☐Sleeping problems ☐Difficulties with daily life (hygiene, bathroom etc)

Please share any relevant information that you would like us to know about your child:

_____
_____
_____
_____

Child's Health History

Has your child undergone Cardiac Surgery? ☐Yes ☐No

If yes, when? _____ What type? _____

Has your child had any other type of surgery? ☐Yes ☐No

If yes, when? _____what type? _____

Has your child had health problems related to exercise? ☐Yes ☐No

☐Chest tightness ☐Cough ☐Wheezing ☐Chest pain

☐Needs frequent breaks ☐Prolonged Shortness of breath ☐Other _____

Does your child participate in any other programs?

_____
_____
_____
_____

Family Health History

Diagnosis	Yes	Relationship	Treatment/Prognosis
Arthritis			
Osteoporosis			
Heart disease			
High Blood Pressure			
High Cholesterol			
Stroke			
Kidney			
Asthma			

Your Child's like and dislikes:

_____
_____
_____

Your child's strengths:

_____
_____
_____

Challenges for your child:

_____
_____
_____