

	Name	Date of Birth
Child		
Father		
Mother		
Sibbling 1		
Sibbling 2		
Referred by		
Date of referral		
Form filled by		
Relationship to the child		
Contact Numbers (Landline / Mobile)		
Email id		
Address		
Childs Paediatrician / Family Doctor		
What are your concerns?		
At what age did it first appear?		
What has been done?		
Married within relatives: Yes / No (If yes; how related?)		
Date of marriage		
How many pregnancies in total		
Previous pregnancy outcome		
How many children do you have?		
Birth order of this child		
Conception	Natural / Artificial (if artificial; OI / IUI / IVF / ICSI)	
Age at conception:	Father:	Mother:
Concerns during pregnancy:	Hypothyroidism / PIH / GDM / Others	
What has been done?		
Hospital admissions? If yes describe		
EDD: or date given for delivery		
Labour onset	Spontaneous / Induced	
Mode of delivery	Normal / Vaccum / Forceps / LSCS	
Indication		
PROM		
Mode of presentation	Vertex / Breech / Transverse	
Cried immediately after birth (Yes / No)		
Cord around neck (Yes / No)		
Birth weight		
Length / Head circumference		
Discharged home on		
NICU Admission (Yes / No)		
If yes; details		
Breast feeding started on		
Discharged on		
Weight at discharge		
Developmental history		
About large movements (Gross motor) like, when did he/she start to hold his head erect, turn over, sitting, standing, and walking. At present what does child do?		

How does your child use his/her hands; like reaching for toys, holding, playing.	
How does your child let you know when he/she requires something? What kind of sounds, gestures words does she use?	
How does your child show that he/she understands when you talk to her. For example when you ask her where is appa, thatha? What does she do?	
How does your child relate to people he/she knows? How is her eye contact?	
How does your child relate to strangers or unknown persons?	
How does your child play with people, toys. What is your child's favourite play	
What are the activities your child can do by herself? Like eating, toileting, etc.	
Which hand does your child prefer to use?	
What kind of activities do you do as a family, like stories, activities	
How does your child show his/her anger or frustration?	
Do you have any concerns about sleep?	
When was gadgets like television mobile introduced?	
Currently how many hours per week does your child spend on these?	
Any other information to share	
Any previous illness / Hospitalisations	
History of convulsions	
Medications currently on	
Languages spoken at home	
Similar Family History:	
Family history of speech delay / developmental delay / others	
Others;	
Current School program	
Current therapy program	
Others	
Have been to Neurologist?	
Ophthalmologist?	
Hearing assessment?	
Genetic test?	
MRI brain / CT Brain?	
EEG?	
Others;	
Previous assessments; when and where	

**Please bring all the records that are relevant during the visit**