Family Services OF THE MERRIMACK VALLEY

430 North Canal Street
Lawrence, MA 01840
978-327-6600
Fax: 978-327-6601
www.FSMV.org

Child Development and Medical Record

Medical Record #_____

Identifying Data

Child's Name:	Birth Date:	Height:	Weight:
Pediatrician:			
Other Medical Providers:			

Current Medications

Medication Allergies: _____

Other Allergies: _____

Birth History

Did mother have any physical or emotional problems during pregnancy?		
Did mother use any prescription drugs during pregnancy?		
Did mother use alcohol, tobacco or recreational drugs during pregnancy?		
Any complications at birth?		
❑ Full Term ❑ Premature ❑ Late By how much?	Birth Weight	Score:
Delivery (check all that apply) ❑ Natural/Vaginal childbirth ❑ Medicated Vaginal Childbirth ❑ Cesarean Section ❑ Short ❑ Long ❑ Hard ❑ Easy		

Early Infant Adjustment Describe:

Sleep-wake pattern:
Responsiveness to people?:
General activity level:
Medical problems:
Other observations:

Child's Name_____ **DOB** _____ **Medical Record #** _____

Feeding

Was the child breast fed? ❑ Yes ❑ No	Bottle-fed? ❑ Yes ❑ No	Colicky? ❑ Yes ❑ No
Does the child have any feeding problems?		

Early Coping *(if applicable, check and describe)*

	Thumb sucking	
	Head banging	
	Rocking	
	Breath holding	
	Hair twisting	
	Eating non-foods (chalk, paper)	
	Fears	
	Depression	
	Anger	
	Favorite objects	

Motor Development

At what month did your child first:

Crawl:	Walk:
Stand Alone:	Dress Self:

Toilet Training

At what age was toilet training started?	At what age was toilet training completed?
Has the child had problems with? ❑ Constipation ❑ Soiling ❑ Daytime Wetting ❑ Nighttime Wetting ❑ Tantrums	
When did problems start?	When did problems stop?

Speech Development

At what age did child use single words?	3 word sentences?
Does the child have any speech/language problems?	
Has the child ever received speech therapy?	

Separations

Does/did child have trouble separating from parent? ❑ Yes ❑ No	
Has the child ever lived away from home? ❑ Yes ❑ No	When?
Has the child spent night away from home? ❑ Yes ❑ No	Problems?
Did the child have problems beginning school? ❑ Yes ❑ No	Explain

Child's Name_____ DOB _____ Medical Record # _____

Social Development

Describe early social experience (playgroups, daycare, etc.)
Describe current friendship patterns:
Describe current school adjustments:
List favorite activities:
Unusual social/emotional/sexual experiences or preoccupations:

Health History

(if applicable, check and describe)

	High fevers	
	Allergies	
	Respiratory infections	
	Other illnesses	
	Hospitalization	
	Operations	
	Medications	
	Serious accidents or injuries	
	Hearing or vision problems	
	Seizures	
	Any recent changes in sleep/eating patterns or general health?	

Any additional information which may be helpful in treating child?

Please see next page for Medical Release and Signatures

Family Services
OF THE MERRIMACK VALLEY

430 North Canal Street
Lawrence, MA 01840
978-327-6600
Fax: 978-327-6601
www.FSMV.org

Child's Name_____ DOB _____ Medical Record # _____

Medical Release

I do _____ do not _____ agree to allow Family Services to request copies of two (2) years of medical documentation about_____ for diagnostic evaluation and treatment planning. I also agree to permit Family Services to release information to my child's physician. This release is in effect while the child is a client at Family Services. It is understood that Family Services is released from all legal responsibility which may arise from this act.

Physician/Pediatrician's Name_____

Physician's Street Address _____ City_____ State ____ Zip _____

Release for Provider who Prescribes Medication (if applicable)

I do _____ do not _____ agree to allow Family Services to request medical information about

_____. I also agree to permit FSI to release information to my child's physician. This release is in effect while the child is a client at Family Services It is understood that Family Services is released from all legal responsibility, which may arise from this act.

Physician/Pediatrician's Name_____

Street Address _____ City_____ State ____ Zip _____

This release is in effect while the child is a client at Family Services I can revoke this authorization with a written signed request at any time, except to the extent that information has already been released or received while acting in reliance with this authorization. I generally am not required to sign this authorization to receive services, unless the services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPPA privacy rules. Information received by Family Services from another source cannot be released to anyone. I understand that Federal Regulation 42CFR, Part 2, protects any drug/alcohol information that I authorize to be released. Finally, I understand that Family Services is released from all legal responsibility that may arise out of this signed permission to release my personal health information.

This authorization is voluntary and made according to my directions.

_____ _____

Client or Parent/Guardian Signature Date Therapist Signature Date

_____

Relationship to client of minor age