CENTRE DE LA PETITE ENFANCE
AWASH UTAMET

MEDICAL HISTORY
SUMMARY FORM

Child's name : _____

Parent's name (respondant's) : _____

Date : ____/____/_____

Pregnancy

Progression of the pregnancy (specificities?) : _____

_____

Type of delivery : _____

_____

Duration of pregnancy : _____

_____

Family situation

The child resides with : _____

Language spoken at home : by mom › _____ by dad › _____

other family members › _____

The child has brothers/sisters : ☐ No ☐ Yes How many ? _____

Family medical history (diagnoses, other?) : _____

_____

_____

T : (418) 748-6161 C : dg@cpeawashutamet.com

Numéro d'entreprise : 166396334
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Health

Health problems : ☐ No ☐ Yes

If yes, please describe : _____

_____

_____

Surgical procedure : ☐ No ☐ Yes

If yes, please describe : _____

_____

_____

Has your child ever met any of the professionals listed below ? ☐ No ☐ Yes

If yes, please check the boxes of the professionnals your child has met with :

☐ Speech Therapist ☐ Occupational Therapist ☐ Physiotherapist ☐ Audiologist ☐ Psychologist

☐ Optometrist ☐ Social Worker

☐ Other : _____

Why has your child met with these professionals ? _____

_____

_____

Do you have any concerns regarding your child ?

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