Child Initial Clinical Assessment Form

Child Information

Full Name: _____

Date of Birth: _____

Gender: _____

Parent/Guardian Name: _____

Contact Number: _____

Reason for Assessment

What are the primary concerns or symptoms?

How long has the child been experiencing these symptoms?

Medical History

Does the child have any known medical conditions? ☐ Yes ☐ No

If yes, please specify: _____

List any current medications: _____

Allergies: _____

Developmental History

Milestones Achieved (check all that apply):

☐ Crawling

☐ Walking

☐ Speaking First Words

☐ Potty Training

Comments on developmental concerns:

Assessment Table

Category	Observation	Notes	Action Required
Physical Appearance			
Emotional State			
Cognitive Development			
Social Interaction			

Parental Consent

☐ **I consent to the assessment of my child and confirm the details provided are accurate.**

Parent/Guardian Name: _____

Signature: _____

Date: _____