



5. a. Has your child ever seen a dentist?  Yes  No Date \_\_\_\_\_

b. If so, for what reason? \_\_\_\_\_  
\_\_\_\_\_

6. a. Does your child have any allergies?  Yes  No

Please list: \_\_\_\_\_  
\_\_\_\_\_

7. By the age of 3½, did your child tend to omit words? (e.g., "I going to school.")  Yes  No

8. Can he/she remember a short message or a telephone number?  Yes  No

9. Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that that all reports and testing results will be confidential.

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date