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CHILD HISTORY

CHILD'S NAME: _____ TODAY'S DATE: _____

BIRTH DATE: _____ AGE: _____ GRADE: _____

CHILD'S GENDER: _____ RACE/ETHNICITY: _____

CHILD'S SCHOOL OR DAYCARE: _____

SPECIAL EDUCATION SERVICES, IF ANY: _____

WHO REFERRED YOU HERE? _____ PHONE:_____

REFERRAL ADDRESS: _____

YOUR RELATIONSHIP TO CHILD: _____

NAME(S) OF PARENT/ LEGAL GUARDIAN(S): _____

IF LEGAL GUARDIAN, RELATIONSHIP TO CHILD: _____

PARENTS' MARITAL STATUS: _____

DESCRIBE CUSTODY ARRANGEMENT, IF APPLICABLE: _____

_____

REASON FOR VISIT

Please describe the reason for your current visit, including any difficulties that your child is having: _____

_____

_____

_____

How long have these difficulties been of concern? _____

When was this problem first noticed?_____

Has your child received evaluation or treatment for the current concern or similar concerns? ◯YES ◯NO

If yes, please describe previous treatment: _____

_____

_____

Is there any legal action currently underway in the family? ◯YES ◯NO

If yes, please explain: _____

Describe any major life event that might be related to your concern (e.g. death in family, physical injury, illness, move, family conflict, natural disaster): _____

_____

_____

DEVELOPMENTAL HISTORY

Was your child adopted? ◯YES ◯NO If yes, child's age at adoption:_____ Age of birth mother?_____

Type of adoption (e.g. agency, foster, international, etc.) _____

PREGNANCY AND DELIVERY

Was this the mothers' first pregnancy? ◯YES ◯NO

Was this is the first live birth? ◯YES ◯NO

Duration of pregnancy (weeks or months): _____

Age of Birth Mother: _____

During the pregnancy, did the mother:

- ☐ Suffer from illness or disease
- ☐ Suffer from an accident
- ☐ Undergo surgery
- ☐ Take medication
- ☐ Undergo x-ray studies
- ☐ Smoke tobacco
- ☐ Consume alcohol
- ☐ Use illegal drugs

Pregnancy complications experienced:

- ☐ Excessive staining or blood loss
- ☐ Threatened miscarriage
- ☐ Infection
- ☐ Toxemia
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Poor nutrition
- ☐ Other:_____

Duration of Labor: _____hours Birth weight:_____ lbs. _____ ozs.

Type of Labor: ◯Spontaneous ◯Induced

Type of Delivery: ◯Vaginal ◯Caesarean

Delivery Complications:

- ☐ None
- ☐ Cord around neck
- ☐ Hemorrhage
- ☐ Placenta problems
- ☐ Other: _____
- ☐ Delay in breathing
- ☐ Injury to infant
- ☐ Fetal distress
- ☐ Meconium aspiration

NEWBORN AND POST-DELIVERY PERIOD

Total days baby was in hospital after delivery: _____ Was your baby in the NICU? ◯YES ◯NO

Birth complications:

- ☐ None
- ☐ Addiction
- ☐ Anemia
- ☐ Breathing trouble
- ☐ Jaundice
- ☐ Infection
- ☐ Seizures
- ☐ Cyanosis (turned blue)
- ☐ Respirator required
- ☐ Resuscitation required
- ☐ Birth defects
- ☐ Intraventricular hemorrhage
- ☐ Other: _____

Briefly describe your child's temperament during infancy: _____

_____

_____

INFANCY-TODDLER PERIOD

Compared to other children, the child's early development was: ◯ Normal ◯ Delayed ◯ Advanced

Were any of the following present during the first few years of life?

- ☐ Colic
- ☐ Reflux
- ☐ Feeding problems
- ☐ Sleeping problems
- ☐ Frequent head banging
- ☐ Excessive restlessness
- ☐ Did not enjoy cuddling
- ☐ Constantly into everything
- ☐ Slow or unable to adapt to changes in routine
- ☐ Excessive high or low activity (circle one)
- ☐ Was not calmed by being held and/or stroked
- ☐ Excessive number of accidents compared to other children
- ☐ Withdrawal or problems adjusting to new people or situations
- ☐ Variable or irregular body functions (sleep, hunger, bowel, etc.)

Were there any special problems in the growth and development of your child during the first year? ◯ YES ◯ NO
If yes, please describe: _____

_____

Looking back, did you ever think that your child was different from other children in some significant or concerning way? If so, when? What did you notice that was different? _____

_____

DEVELOPMENTAL MILESTONES

The following is a list of infant developmental milestones. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

BEHAVIOR	AGE	BEHAVIOR	AGE
Walked alone	_____	Stayed dry at night	_____
Spoke first single word	_____	Fed self	_____
Put words together	_____	Rode tricycle	_____
Became toilet trained	_____	Other (_____)	_____

CHILD'S MEDICAL HISTORY

Pediatrician's Name: _____

Other Physician's Name(s): _____

If the child has ever been treated with medication other than for colds and minor infections, please list medications below. Place a check under "current" for those medications the child is currently taking.

MEDICATION NAME	AGE	REASON PRESCRIBED	CURRENT
_____	_____	_____	Y◯ N◯
_____	_____	_____	Y◯ N◯
_____	_____	_____	Y◯ N◯

Has your child ever suffered from a head injury that caused confusion or loss of consciousness? YES◯ NO◯

CHILD'S MEDICAL HISTORY (CONTINUED)

Place a check next to any illness or condition that the child has or had. When you check an item, also note the approximate age of the child at the time of the illness.

ILLNESS OR CONDITION	AGES	ILLNESS OR CONDITION	AGES
☐ Addiction or drug dependence		☐ Headaches	
☐ AIDS or HIV positive		☐ Heart disease or problems	
☐ Allergies		☐ Herpes	
☐ Anemia		☐ High blood pressure	
☐ Aneurysm		☐ Jaundice	
☐ Arteriovenous/Chiari Malformation (AVM)		☐ Lead poisoning	
☐ Arthritis		☐ Leukemia	
☐ Asthma		☐ Malnutrition	
☐ Ataxia		☐ Meningitis	
☐ Automobile accident		☐ Muscular disease	
☐ Back pains or problems		☐ Pain problems (_____)	
☐ Bleeding problems		☐ Paralysis	
☐ Bone or joint disease		☐ Pituitary disorder	
☐ Broken bones		☐ Pneumonia	
☐ Cancer		☐ Poisoning	
☐ Chorea (movement disorder)		☐ Poliomyelitis	
☐ Coma		☐ Respiratory illness	
☐ Cystic Fibrosis		☐ Rheumatoid Arthritis	
☐ Dazed or unconscious		☐ Scarlet fever	
☐ Dementia		☐ Sensory losses (hearing, eye sight)	
☐ Diabetes		☐ Sexual molestation	
☐ Dysarthia (language disorder)		☐ Sexually transmitted disease (STD)	
☐ Dyspraxia (or Apraxia)		☐ Sinus infections	
☐ Ear infections (PE tubes)		☐ Speech and language problems	
☐ Other ear or hearing problems		☐ Spells or fits (_____)	
☐ Eczema or hives		☐ Stroke	
☐ Electrical or chemical shock		☐ Substance dependence	
☐ Encephalitis		☐ Suicide attempts or thoughts	
☐ Epilepsy, seizures or convulsions		☐ Sunstroke or heat exhaustion	
☐ Fainting spells		☐ Thyroid disorder or problem	
☐ Fetal Alcohol Syndrome		☐ Tuberculosis	
☐ Fever (if very high or prolonged)		☐ Tumor	
☐ Gender Transition		☐ Visual or eye problems	
☐ Guillan-Barré Syndrome		☐ Whooping cough	
☐ Head injury		☐ Other: _____	

Other major medical problems not mentioned (accidents, illnesses, or syndromes): _____

_____

Indicate if the child has undergone any of these medical tests in the past (place check and give approximate age or ages when test was given):

TEST	AGE	TEST	AGE
☐ Academic/Educational testing		☐ Chromosome study	
☐ Psychological testing		☐ Ultrasound	
☐ Electroencephalogram		☐ Skull or Head X-rays	
☐ Evoked Potentials (ERP)		☐ CT scans (_____)	
☐ Ophthalmology (vision) evaluation		☐ MRI scans (_____)	
☐ Audiology (hearing) evaluation		Other: _____	

FAMILY MEDICAL HISTORY

Place a check next to any illness, condition, or problem experienced by any genetic relative. When you check an item, please note the relative's relationship to you. If any problems run in the family, please write them at the end of the list.

	CONDITION	RELATIONSHIP TO CHILD
☐	Alcoholism	
☐	Antisocial (criminal) behavior	
☐	Autism Spectrum Disorder	
☐	Asperger's Disorder/Schizoid Personality	
☐	Bipolar Disorder (manic-depressive)	
☐	Dementia, Alzheimers	
☐	Depression	
☐	Drug addiction or drug problems	
☐	Headaches (e.g. migraines)	
☐	ADHD/ADD (hyperactivity/attention problems)	
☐	Learning problems	
☐	Developmental Delay/mental retardation	
☐	Tic or movement disorders	
☐	Schizophrenia or psychosis	
☐	Seizures, epilepsy, or convulsions	
☐	Sexual/physical abuse in childhood	
☐	Suicide or suicide attempt	
☐	Borderline or Narcissistic Personality Disorder	
☐	Post-Traumatic Stress Disorder (PTSD)	
☐	Obsessive Compulsive Disorder (OCD)	
☐	Nervous or neurological illness	
☐	Other Mental Illness (_____)	
☐	Other (specify_____)	

EDUCATIONAL HISTORY

CURRENT SCHOOL: _____ CURRENT GRADE: _____

SCHOOL PHONE:_____ PRINCIPAL:_____

LEAD TEACHER:_____

SPECIAL EDUCATION CLASSIFICATION (if any):_____

GRADES REPEATED (if any):_____

EDUCATIONAL HISTORY (CONTINUED)

Describe any academic or behavioral concerns at school: _____

Previous school placements, changes of school, or school experiences: _____

List or estimate current report card grades or child's GPA: _____

Describe any past or current services or modifications at school: _____

Describe private educational services (speech/language, occupational therapy, tutoring, behavioral): _____

Is there any other information that might help me to understand your child? _____

HOME INFORMATION

Mother's name: _____ Age: _____

Education: _____ Occupation: _____

Father's name: _____ Age: _____

Education: _____ Occupation: _____

Stepmother's name: _____ Age: _____

Education: _____ Occupation: _____

Stepfather's name: _____ Age: _____

Education: _____ Occupation: _____

If parents are separated or divorced, how old was the child when the separation occurred? _____

Primary language spoken at home: _____

Any other languages spoken at home?: _____

HOME INFORMATION (CONTINUED)

List siblings and others living in the home:

NAME	RELATIONSHIP TO CHILD	AGE

List any siblings living outside of the home:

NAME	RELATIONSHIP TO CHILD	AGE

Provide any other important information about home: _____

What discipline techniques are effective in your home? _____

What discipline techniques are usually ineffective? _____

What are your child's favorite activities? _____

What are your child's assets or strengths? _____