

**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
- \_\_\_\_\_ Other: \_\_\_\_\_
- \_\_\_\_\_ Jaundice
- \_\_\_\_\_ Infection
- \_\_\_\_\_ Seizures
- \_\_\_\_\_ Cyanosis (turned blue)
- \_\_\_\_\_ Respirator required
- \_\_\_\_\_ Resuscitation required
- \_\_\_\_\_ Birth defects
- \_\_\_\_\_ Intraventricular hemorrhage

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?

- |  |   |
|--|---|
| <input type="checkbox"/> Colic<br><input type="checkbox"/> Reflux<br><input type="checkbox"/> Feeding problems<br><input type="checkbox"/> Sleeping problems<br><input type="checkbox"/> Frequent head banging<br><input type="checkbox"/> Excessive restlessness<br><input type="checkbox"/> Did not enjoy cuddling | <input type="checkbox"/> Constantly into everything<br><input type="checkbox"/> Slow or unable to adapt to changes in routine<br><input type="checkbox"/> Excessive <u>high</u> or <u>low</u> activity (circle one)<br><input type="checkbox"/> Was not calmed by being held and/or stroked<br><input type="checkbox"/> Excessive number of accidents compared to other children<br><input type="checkbox"/> Withdrawal or problems adjusting to new people or situations<br><input type="checkbox"/> 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
<input type="checkbox"/> Addiction or drug dependence	_____	<input type="checkbox"/> Headaches	_____
<input type="checkbox"/> AIDS or HIV positive	_____	<input type="checkbox"/> Heart disease or problems	_____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Herpes	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> High blood pressure	_____
<input type="checkbox"/> Aneurysm	_____	<input type="checkbox"/> Jaundice	_____
<input type="checkbox"/> Arteriovenous/Chiari Malformation (AVM)	_____	<input type="checkbox"/> Lead poisoning	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Leukemia	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Malnutrition	_____
<input type="checkbox"/> Ataxia	_____	<input type="checkbox"/> Meningitis	_____
<input type="checkbox"/> Automobile accident	_____	<input type="checkbox"/> Muscular disease	_____
<input type="checkbox"/> Back pains or problems	_____	<input type="checkbox"/> Pain problems (_____)	_____
<input type="checkbox"/> Bleeding problems	_____	<input type="checkbox"/> Paralysis	_____
<input type="checkbox"/> Bone or joint disease	_____	<input type="checkbox"/> Pituitary disorder	_____
<input type="checkbox"/> Broken bones	_____	<input type="checkbox"/> Pneumonia	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Poisoning	_____
<input type="checkbox"/> Chorea (movement disorder)	_____	<input type="checkbox"/> Poliomyelitis	_____
<input type="checkbox"/> Coma	_____	<input type="checkbox"/> Respiratory illness	_____
<input type="checkbox"/> Cystic Fibrosis	_____	<input type="checkbox"/> Rheumatoid Arthritis	_____
<input type="checkbox"/> Dazed or unconscious	_____	<input type="checkbox"/> Scarlet fever	_____
<input type="checkbox"/> Dementia	_____	<input type="checkbox"/> Sensory losses (hearing, eye sight)	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Sexual molestation	_____
<input type="checkbox"/> Dysarthria (language disorder)	_____	<input type="checkbox"/> Sexually transmitted disease (STD)	_____
<input type="checkbox"/> Dyspraxia (or Apraxia)	_____	<input type="checkbox"/> Sinus infections	_____
<input type="checkbox"/> Ear infections (PE tubes)	_____	<input type="checkbox"/> Speech and language problems	_____
<input type="checkbox"/> Other ear or hearing problems	_____	<input type="checkbox"/> Spells or fits (_____)	_____
<input type="checkbox"/> Eczema or hives	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Electrical or chemical shock	_____	<input type="checkbox"/> Substance dependence	_____
<input type="checkbox"/> Encephalitis	_____	<input type="checkbox"/> Suicide attempts or thoughts	_____
<input type="checkbox"/> Epilepsy, seizures or convulsions	_____	<input type="checkbox"/> Sunstroke or heat exhaustion	_____
<input type="checkbox"/> Fainting spells	_____	<input type="checkbox"/> Thyroid disorder or problem	_____
<input type="checkbox"/> Fetal Alcohol Syndrome	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Fever (if very high or prolonged)	_____	<input type="checkbox"/> Tumor	_____
<input type="checkbox"/> Gender Transition	_____	<input type="checkbox"/> Visual or eye problems	_____
<input type="checkbox"/> Guillan-Barré Syndrome	_____	<input type="checkbox"/> Whooping cough	_____
<input type="checkbox"/> Head injury	_____	<input type="checkbox"/> 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
<input type="checkbox"/> Academic/Educational testing	_____	<input type="checkbox"/> Chromosome study	_____
<input type="checkbox"/> Psychological testing	_____	<input type="checkbox"/> Ultrasound	_____
<input type="checkbox"/> Electroencephalogram	_____	<input type="checkbox"/> Skull or Head X-rays	_____
<input type="checkbox"/> Evoked Potentials (ERP)	_____	<input type="checkbox"/> CT scans (_____)	_____
<input type="checkbox"/> Ophthalmology (vision) evaluation	_____	<input type="checkbox"/> MRI scans (_____)	_____
<input type="checkbox"/> Audiology (hearing) evaluation	_____	<input type="checkbox"/> 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
<input type="checkbox"/> Alcoholism	_____
<input type="checkbox"/> Antisocial (criminal) behavior	_____
<input type="checkbox"/> Autism Spectrum Disorder	_____
<input type="checkbox"/> Asperger's Disorder/Schizoid Personality	_____
<input type="checkbox"/> Bipolar Disorder (manic-depressive)	_____
<input type="checkbox"/> Dementia, Alzheimers	_____
<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Drug addiction or drug problems	_____
<input type="checkbox"/> Headaches (e.g. migraines)	_____
<input type="checkbox"/> ADHD/ADD (hyperactivity/attention problems)	_____
<input type="checkbox"/> Learning problems	_____
<input type="checkbox"/> Developmental Delay/mental retardation	_____
<input type="checkbox"/> Tic or movement disorders	_____
<input type="checkbox"/> Schizophrenia or psychosis	_____
<input type="checkbox"/> Seizures, epilepsy, or convulsions	_____
<input type="checkbox"/> Sexual/physical abuse in childhood	_____
<input type="checkbox"/> Suicide or suicide attempt	_____
<input type="checkbox"/> Borderline or Narcissistic Personality Disorder	_____
<input type="checkbox"/> Post-Traumatic Stress Disorder (PTSD)	_____
<input type="checkbox"/> Obsessive Compulsive Disorder (OCD)	_____
<input type="checkbox"/> Nervous or neurological illness	_____

## EDUCATIONAL HISTORY

Other Mental Illness ( \_\_\_\_\_ ) \_\_\_\_\_

Other (specify \_\_\_\_\_ ) \_\_\_\_\_

CURRENT SCHOOL: \_\_\_\_\_ CURRENT GRADE: \_\_\_\_\_

SCHOOL PHONE: \_\_\_\_\_ PRINCIPAL: \_\_\_\_\_

LEAD TEACHER: \_\_\_\_\_

SPECIAL EDUCATION CLASSIFICATION (if any): \_\_\_\_\_

## EDUCATIONAL HISTORY (CONTINUED)

GRADES REPEATED (if any): \_\_\_\_\_

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? \_\_\_\_\_

**HOME INFORMATION (CONTINUED)**

Primary language spoken at home: \_\_\_\_\_

Any other languages spoken at home?: \_\_\_\_\_

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? \_\_\_\_\_

\_\_\_\_\_

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