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# CHILDHOOD HISTORY FORM

Child's Full Name _____ Nickname _____

Birth Date _____ Age ____ - years, ____ - months Sex _____

Home Address _____
STREET

_____
CITY STATE Zip

Home Phone (  ) _____ Cell (  ) _____

Child's School _____
NAME ADDRESS

Grade _____ Special Placement (if any) _____

Child's Ethnicity: □ Caucasian □ African-American □ Hispanic □ Asian □ Other _____

Languages Spoken at Home: □ English □ Other _____

**FAMILY HISTORY:**

Child is presently living with:

□ Both Parents □ Mother □ Father □ Mother/Stepfather

□ Father/Stepmother □ Legal Guardian □ Other (Please Specify) _____

Is child adopted? □ Yes □ No; If yes, which parent(s) [if any] does child live: □ natural □ adoptive

Child's Age at Adoption: _____

Status of Parent's Marriage: □ Married (How Long _____) □ Separated (How long _____)

□ Divorced (How Long _____ / Child's Age at Divorce _____) □ Widowed □ Single

Who has legal custody of Child: _____

Non-residential adults involved with Child on a regular basis:

_____

_____

*Source of Referral:* Name _____

_____
STREET

_____
CITY STATE Zip

Phone: (  ) _____ Email: _____

**PRESENTING PROBLEMS:**

A. What concerns do you have about your child and why are you seeking help for your child at this time? _____

B. What kind of information or assistance are you hoping to obtain for this child?

C. Does the child have any behavioral/emotional/social problems at home or at school? □ Yes □ No; If yes, please describe: _____

D. Does the child have any school studying and/or learning problems? □ Yes □ No; If yes, please describe: _____

E. Please describe any other problems your child may have that may be of relevance to this evaluation: _____

F. Please lest all past neurological, psychiatric, psychological, neuropsychological, educational, speech & language, or other types of evaluations administered to this child (Please indicate when and by whom these were done):

| Evaluated At: | By: | Date: |
|---|---|---|

**Please attach copies of these reports. For a comprehensive evaluation to be provided on your child it is essential to have copies of all these reports.**

**PRESENTING PROBLEMS:** (continued)

G. Please list all past or present interventions, treatment, or remediation this child has received or is receiving, at school or privately, including Physical Therapy, Occupational Therapy, Speech & Language Therapy, etc... (Please indicate when and by whom these were done):

Received At: By: Date:

**PARENTS:**

**Mother** _____

Occupation _____ Business Phone: ( )

Address (if different from above): _____
STREET CITY

_____ Home Ph. ( ) Cell ( )
STATE ZIP

Email: _____

Age _____ Age at time of pregnancy with patient _____

School: Highest grade completed _____

Learning problems _____

Attention Problems _____

Behavior Problems _____

Medical Problems _____

Have any of Mother's blood relatives experienced problems similar to those your child is experiencing? If so, describe: _____

**Father** _____ Age _____
Occupation _____ Business Phone: (  ) _____
Address (if different from above): _____
STREET CITY

_____ Home Ph. (  ) _____ Cell (  ) _____
STATE ZIP

Email: _____

School: Highest grade completed _____

Learning problems _____
_____

Attention Problems _____
_____

Behavior Problems _____
_____

Medical Problems _____
_____
_____

Have any of Father's blood relatives experienced problems similar to those your child is experiencing? If so, describe: _____
_____
_____
_____

**SIBLINGS:**

| *Name* | *Age* | *Medical, Social, or School Problems* |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

**PREGNANCY:** [Complications]

Excessive vomiting _____ Hospitalization required _____
Excessive staining/blood loss _____ Threatened miscarriage _____
Infections(s) (specify) _____
Toxemia _____ Operations(s) (specify) _____
Other illness(es) (specify) _____
Smoking during pregnancy _____ # cigarettes per day _____
Alcoholic consumption during pregnancy _____
Describe if beyond an occasional drink _____
Medications taken during pregnancy _____
X-ray studies during pregnancy _____
Duration of pregnancy (weeks) _____

**DELIVERY:**

Type of Labor: Spontaneous _____ Induced _____ Duration (hrs.) _____
Type of Delivery: Normal _____ Breech _____ Cesarean _____
Complications: Cord around neck _____ Hemorrhage _____
Infant injured during delivery _____ Other _____
Birth Weight _____
APGAR Scores: First _____ Second _____

**POST DELIVERY PERIOD:**

Jaundice _____ Cyanosis (turned blue) _____ Incubator Care _____
Infection (specify) _____
Number of day's infant was in the hospital after delivery _____
Special or Intensive Care _____
Any birth defects? □ Yes □ No; If yes, describe _____

**INFANCY PERIOD:**

Please rate the child on the following behaviors: Circle 1 if the behavior on the left was present the majority of the time. Circle 5 if the behavior on the right was present the majority of the time. Stages in between are represented by 2, 3, and 4. If there are two behaviors listed (e.g., tantrums an head banging), please check the one that was present.

| | | | | | | |
|---|---|---|---|---|---|---|
| quiet and content | 1 | 2 | 3 | 4 | 5 | colicky and irritable |
| very easy to read | 1 | 2 | 3 | 4 | 5 | daily feeding problems |
| slept well | 1 | 2 | 3 | 4 | 5 | frequent sleeping problems |
| usually relaxed | 1 | 2 | 3 | 4 | 5 | often restless |
| underactive | 1 | 2 | 3 | 4 | 5 | overactive |
| cuddly, easy to hold | 1 | 2 | 3 | 4 | 5 | did not enjoy cuddling |
| easily calmed down | 1 | 2 | 3 | 4 | 5 | □ tantrums □ head banging |
| cautious and careful | 1 | 2 | 3 | 4 | 5 | □ accident prone □ daredevil |
| coordinated | 1 | 2 | 3 | 4 | 5 | uncoordinated |
| enjoyed eye contact | 1 | 2 | 3 | 4 | 5 | avoided eye contact |
| liked people | 1 | 2 | 3 | 4 | 5 | disliked contact with people |

**TEMPERAMENT**

Please rate the following behaviors as your child appeared during infancy and toddlerhood:

**Activity Level** – How active has your child been from an early age? _____

_____

**Distractibility** – How well did you child pay attention? _____

_____

**Adaptability** – How well did your child deal with transition and change? _____

_____

**Approach/Withdrawal** – How well did your child respond to new things (i.e. places, people, food, etc.)? _____

_____

**TEMPERAMENT:** (continued)

**Intensity** – Whether happy or unhappy, how aware are others of your child's feelings? __

**Mood** – What was your child's basic mood? _____

**Regularity** – How predictable was your child in patterns of sleep, appetite, etc? _____

**MEDICAL HISTORY:**

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information:

Childhood diseases (describe ages and any complications) _____

Operations _____
Hospitalizations for illness _____

Head injuries _____
Convulsions _____ with fever _____without fever _____
Coma _____
Persistent high fevers _____
Eye problems _____
Tics (i.e., eye blinking, sniffing, any repetitive, non-purposeful movements) _____

Date of Last Vision Test _____ Were results normal? □ Yes □ No;
If no, please explain: _____
Ear problems _____
Date of Last Hearing Test _____ Were results normal? □ Yes □ No;
If no, please explain: _____
Allergies or asthma _____
Poisoning _____
Sleep
Does your child settle down to sleep? _____
Sleep through the night without disruption? _____
Experience nightmares, night terrors, sleep walking, sleep talking? _____
Is your child a very restless sleeper? _____
Does your child snore? _____
Appetite _____

**PRESENT MEDICAL STATUS:**

Height _____ Weight _____
Present illnesses for which the child is being treated _____

Medications child is taking on on-going basis _____

**DEVELOPMENTAL MILESTONES**

If you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall exactly, check item at right:

| | *Age* | *Early* | *Normal* | *Late* |
|---|---|---|---|---|
| Smiled | | | | |
| Sat without support | | | | |
| Crawled | | | | |
| Stood without support | | | | |
| Walked without assistance | | | | |
| Spoke first words | | | | |
| Said phrases | | | | |
| Said sentences | | | | |
| Bladder trained, day | | | | |
| Bladder trained, night | | | | |
| Bowel trained, day | | | | |
| Bowel trained, night | | | | |
| Rode tricycle | | | | |
| Rode bicycle (without training wheels) | | | | |
| Buttoned clothing | | | | |
| Tied shoelaces | | | | |
| Used a crayon | | | | |
| Named colors | | | | |
| Named coins | | | | |
| Played with dolls/stuffed animals | | | | |
| Imaginative Play | | | | |
| Play in cooperation with other children | | | | |
| Said alphabet in order | | | | |
| Began to read | | | | |

**COORDINATION:**

Rate your child on the following skills:

| | *Good* | *Average* | *Poor* |
|---|---|---|---|
| Walking | | | |
| Running | | | |
| Throwing | | | |
| Catching | | | |
| Shoelace tying | | | |
| Buttoning | | | |
| Writing | | | |
| Athletic abilities | | | |
| Excessive number of accidents compared to other children | | | |
| | | | |
| | | | |

**NEUROLOGICAL & PSYCHIATRIC HISTORY:**

1) Please list current and previous medications taken for more than three months:
Current: _____
_____
Previous: _____
_____

2) Has your child every experienced (please circle if applicable): meningitis, encephalitis, stroke, brain hemorrhage, narcolepsy, sleep disorders, head injury, coma, loss of consciousness, tumor, toxic metal exposure, headaches, seizures, tics, fainting, tremors, and/or vertigo? If yes, please describe: _____
_____
_____
_____

3) Has your child been diagnosed with (please circle if applicable): cerebral palsy, muscular dystrophy, multiple sclerosis, mental retardation, and/or central nervous system structural defect? If yes, please describe: _____
_____
_____

4) Has your child been diagnosed with a neurobehavioral disorder such as (please circle if applicable): Tourette's Syndrome, learning disabilities, dyslexia, ADD/ADHD, autism, Asperger's Syndrome, hyperlexia, processing deficits, Obsessive Compulsive Disorder (OCD), Oppositional Defiant Disorder (ODD), Non-Verbal Learning Disability (NVLD), and/or executive function deficits? If yes, please describe: _____
_____
_____
_____

5) Has your child used cigarettes, drugs, or alcohol? If yes, please describe: _____
_____
_____

6) Has your child been diagnosed or shown symptoms of (please circle if applicable): emotional/behavior disorders, depression, manic/depression, bipolor disorder, schizophrenia, phobias, panic attacks, anxiety, and/or eating disorders? If yes, please describe: _____
_____
_____

7) Has your child been the victim of emotional, physical, or sexual abuse? If yes, please describe: _____
_____
_____
_____

**EDUCATIONAL HISTORY:**

**A. Daycare:**

Does or did this child attend daycare before preschool? □ Yes □ No
If yes, please provide name and location of the child caregiver:

_____
Name City State

Between what ages? _____ □ Full-Time □ Part-Time

Any problems in daycare? □ Yes □ No; If yes, please describe: _____
_____
_____
_____

**B. Preschool:**

Does or did this child attend preschool? □ Yes □ No
If yes, please provide name and location of the preschool:

_____
Name City State

Between what ages? _____ □ Full Day □ Half Day

Any problems in preschool? □ Yes □ No; If yes, please describe: _____
_____
_____
_____

**C. Kindergarten:**

Does or did this child attend kindergarten? □ Yes □ No
If yes, please provide name and location of the kindergarten:

_____
Name City State

What age did child enter kindergarten? _____ □ Full Day □ Half Day

Did child have problems separating? □ Yes □ No; If yes, please describe: _____
_____
_____
_____

Any other problems in kindergarten? □ Yes □ No; If yes, please describe: _____
_____
_____
_____

Pre- or Post- kindergarten program/care: _____
_____

**D. <u>Elementary / High School:</u>**

List names and locations of school attended:

| Name | City | State |
|---|---|---|
| Name | City | State |
| Name | City | State |
| Name | City | State |

Name/Address of Current School:

| Name | City | State |
|---|---|---|

( ) _____
Phone Teachers Name

Please indicate whether this child has had any of the following school experiences:

1. Age child entered first grade: _____
2. Was child retained a grade in school? □ Yes □ No; If yes, when and why?

   _____
3. Has child skipped a grade in school? □ Yes □ No; If yes, when and why?

   _____
4. Does child have difficulty with reading? □ Yes □ No; If yes, please describe:

   _____

   _____
5. Does child have difficulty with math? □ Yes □ No; If yes, please describe:

   _____

   _____
6. Has child been placed in a special education/resource classroom? □ Yes □ No

   If yes, number of hours per day_____
7. Does this child dislike going to school? □ Yes □ No

   If yes, please describe: _____

**E. <u>Current School Services or Placement:</u>** (via IDEA, IEP, MDC, or 504 Plan)

LD: _____

ED: _____

Speech & Language: _____

OT / PT: _____

Social Work / Counseling: _____

Consultation: _____

Does your child's teacher describe any of the following as significant problems?

- ☐ Doesn't sit still in his or her seat _____
- ☐ Frequently gets up and walks around the classroom _____
- ☐ Shouts out. Doesn't wait to be called on _____
- ☐ Won't wait his or her turn _____
- ☐ Doesn't cooperate well in group activities _____
- ☐ Typically does better in a one-to-one relationship _____
- ☐ Doesn't respect the rights of others _____
- ☐ Doesn't pay attention during storytelling or show and tell _____
- ☐ Describe briefly any *other* classroom behavioral problems _____

_____

_____

**PEER RELATIONSHIPS:**

Does your child seek friendships with peers? _____

Is your child sought by peers for friendship? _____

Does child play with children primarily his/her own age: ☐ Own Age ☐ Younger ☐ Older

Describe briefly any problems your child may have with peers: _____

_____

_____

_____

_____

**HOME BEHAVIOR:**

All children exhibit, to some degree, the behaviors listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her age.

- ☐ Fidgets with hands, feet or squirms in seat _____
- ☐ Has difficulty remaining seated when required to do so _____
- ☐ Easily distracted by extraneous stimulation _____
- ☐ Has difficulty awaiting his turn in games or group situations _____
- ☐ Blurts out answers to questions before they have been completed _____

**HOME BEHAVIOR** (continued):

- Has problems following through with instructions (usually not due to opposition or failure to comprehend _____
- Has difficulty paying attention during tasks or play activities _____
- Shifts from one uncompleted activity to another _____
- Has difficulty playing quietly _____
- Often talks excessively _____
- Interrupts or intrudes on others (often not purposeful or planned but impulsive) _____
- Does not appear to listen to what is being said _____
- Loses things necessary for tasks or activities at home _____
- Boundless energy and poor judgment _____
- Impulsivity (poor self-control) _____
- History of temper tantrums _____
- Temper outbursts _____
- Frustrates easily _____
- Sloppy table manners _____
- Sudden outbursts of physical abuse of other children _____
- Acts like he or she is driven by a motor _____
- Wears out shoes more frequently than siblings _____
- Excessive number of accidents _____
- Doesn't seem to learn from experience _____
- Poor memory _____
- A "different child" _____
- How well does your child work for a short-term reward? _____
- How well does your child work for a long-term reward? _____

Does your child create more problems, either purposeful or non-purposeful, within the home setting than his or her siblings do? _____

_____

_____

Does your child have difficulty benefiting from his experiences? _____

_____

_____

Types of discipline you use with your child _____

_____

_____

Is there a particular form of discipline that has proven effective? _____

_____

_____

Have you participated in parenting class or obtained other forms of information concerning discipline and behavior management? _____

_____

_____

## INTERESTS AND ACCOMPLISHMENTS

What are your child's main hobbies and interests? _____

_____

What are your child's areas of greatest accomplishment? _____

_____

What does your child enjoy doing most? _____

_____

What does your child dislike doing most? _____

_____

What do you like about your child? _____

_____

## LIST NAMES AND ADDRESSES OF ANY OTHER PROFESSIONALS CONSULTED:

(Including family doctor)

1. _____
2. _____
3. _____
4. _____
5. _____

## ADDITIONAL REMARKS:

Please write any additional remarks you may wish to make regarding your child.