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CHILDREN'S HISTORY FORM

Please complete this form to the best of your knowledge and return it to us before your child's appointment. Some questions may not be applicable to your child. If you need more space or wish to make any additional comments, please attach a separate sheet.

Name of person filling out this form: _____ Date: _____
Relationship to child: _____

Child's Name: _____
Sex: _____ Age: _____ Birth Date: _____

School: _____ Grade: _____

Pediatrician: _____ Phone: _____
If you would like a copy of the report to go to your child's pediatrician, please list the doctor's address here:

_____
_____
_____

Referred by: _____

Reason(s) for consultation or evaluation:
(What are the main questions you would like answered?) _____

_____
_____
_____

Has your child had previous evaluations? ☐yes ☐no If yes, when and by whom?
(Psychological, psychoeducational, or neuropsychological evaluation either at school or privately, in the past)

_____
_____

If you have copies of these reports, (or any other pertinent records) please fax them to us before your child's appointment.

FAMILY HISTORY

(List parents first, then children in birth order)

	NAME	Check if living in the home	AGE	OCCUPATION	EDUCATION / GRADE
FATHER		☐			
STEP-FATHER		☐			
MOTHER		☐			
STEP-MOTHER		☐			
CHILD		☐			
CHILD		☐			
CHILD		☐			
CHILD		☐			

Are there significant conflicts…
- between parents? ☐yes ☐no
- between parent and child? ☐yes ☐no
- between children? ☐yes ☐no

Do parents agree on how to discipline your child? ☐yes ☐no
Who disciplines and how? _____

How does your child respond to discipline? _____

PREGNANCY

Is this child adopted? ☐yes ☐no If yes, at what age did you get your child? _____

Were there any of the following complications during this pregnancy? (if so, indicate the month)

Anemia	☐	High blood pressure	☐
Swollen ankles	☐	Kidney disease	☐
Heart disease	☐	German Measles	☐
Toxemia	☐	Staining	☐
Bleeding	☐	Vomiting	☐
Virus	☐	Threatened miscarriage	☐
		Early contractions	☐
		Rh or other blood incompatibility	☐

List any other complications you may have had:
_____
_____

List any of the following experienced during this pregnancy:
- Chronic illness(es) such as diabetes, kidney infection, thyroid, etc… _____
  - Other illnesses: _____
- Hospitalizations (date & reason) _____
- Surgeries _____
- Injuries _____
- Medications taken _____

BIRTH HISTORY

Hospital name: _____ Hours from first contraction to birth: _____
Name any anesthesia administered:
List any medication(s) administered and why: _____

_____

Was Labor induced? ☐yes ☐no
If yes, how and why? _____
Was your child born headfirst? ☐yes ☐no ☐don't know
Were forceps used? ☐yes ☐no ☐don't know
If yes, why? _____
Did you have a cesarean section? ☐yes ☐no
If yes, why? _____
Was this a multiple birth? ☐yes ☐no If yes, how many? _____

Did your baby have any of the following:
bruises ☐yes ☐no If yes, where? _____
birthmarks ☐yes ☐no If yes, where? _____
breathing problems ☐yes ☐no ☐don't know
cord around the neck ☐yes ☐no ☐don't know

Did your baby cry quickly? ☐yes ☐no ☐don't know

Was your baby's color normal? ☐Yes ☐No ☐don't know
If your baby's color was yellow (jaundiced), did s/he receive any of the following:
Oxygen ☐yes ☐no How long? _____
Transfusions ☐yes ☐no How many? _____
Phototherapy ☐yes ☐no How long? _____

Were there any other complications before you took your baby home?

_____

EARLY HISTORY

GENERAL
Did your baby have feeding problems? ☐yes ☐no
If so, describe: _____
Was your baby colicky? ☐yes ☐no How long: _____
Did your baby require formula changes? ☐yes ☐no
If so, describe: _____
Did your baby have difficulty with any of the following:
☐sucking ☐chewing ☐drooling past 2 ½ months
Was your baby ☐normally active ☐limp ☐stiff
Did your baby show unusual trembling? ☐yes ☐no How long: _____
As an infant or toddler did your child have poor muscle control (ie weakness)? ☐yes ☐no
If yes, in which of the following: ☐neck ☐trunk ☐legs ☐chest ☐arms ☐fingers
Did your baby fail to grow normally? ☐yes ☐no
Did your baby fail to gain weight? ☐yes ☐no
Was this baby different in any way from his/her siblings? ☐yes ☐no

If so, describe how: _____

_____

TOILETING

Toilet trained ☐early ☐average(13-36 months) ☐late
Did your child have enuresis (bedwetting)? ☐yes ☐no
If so, age began: _____ age controlled: _____
Did your child have urine accidents during the day? ☐yes ☐no
Did your child have soiling accidents? ☐yes ☐no

MOTOR MILESTONES

At what age did your child:

sit alone	_____	tie shoes	_____	pedal tricycle	_____
feed self	_____	dress self	_____	ride bicycle	_____
walk without holding on	_____			swim	_____

Crawled ☐early ☐average(6-9 months) ☐late
Walked 2-3 steps alone ☐early ☐average(9-18 months) ☐late
Which hand does your child prefer? ☐left ☐right age est. _____
Does your child switch hands? ☐yes ☐no

LANGUAGE MILESTONES

At what age did your child:
speak first words _____ sentence structure _____ put 2-3 words together _____
Speech problems? ☐yes ☐no
If so, describe: _____
Followed simple commands ☐early ☐average(12-18 months) ☐late
Used single words/sentences ☐early ☐average(12-24 months) ☐late

MEDICAL HISTORY

Current height: _____ ft. _____ in. Weight: _____ lbs.
Has your child ever experienced:

high or prolonged fevers	☐yes	☐no	If yes, 104 (40C) or higher for more than a few hours?
frequent ear infections	☐yes	☐no	If yes, were tubes placed?
visual defects	☐yes	☐no	
hearing defects	☐yes	☐no	
broken bone(s)	☐yes	☐no	

Does your child frequently complain of any of the following:

headache	☐yes	☐no	stomachaches	☐yes	☐no
dizziness	☐yes	☐no	chronic constipation	☐yes	☐no
weakness	☐yes	☐no	chronic diarrhea	☐yes	☐no
nausea	☐yes	☐no	trouble hearing	☐yes	☐no
			vision issues	☐yes	☐no

Has your child ever swallowed any paint, poison, drug, or non-food object? ☐yes ☐no
If so, at what age? Describe: _____
Has your child ever had a seizure due to a fever or unknown causes? ☐yes ☐no
If so, describe the age and nature of the seizure:

Has your child ever been “dazed” (“dinged” or “bell rung”) or knocked unconscious? ☐yes ☐no
If yes, describe: _____
Has your child ever suffered a brain injury in an accident or assault?

If yes, describe: _____

Did anyone in your immediate family or other relative have any of the following?

			WHO:
problems similar to your child	☐yes	☐no	_____
neurological disease	☐yes	☐no	_____
seizures (epilepsy)	☐yes	☐no	_____
emotional problems	☐yes	☐no	_____
mental retardation	☐yes	☐no	_____
hyperactivity	☐yes	☐no	_____
learning problems	☐yes	☐no	_____
reading or spelling difficulties	☐yes	☐no	_____
speech or language problems	☐yes	☐no	_____

Does any disease run in your family? ☐yes ☐no

If yes, what? _____

CURRENT CHILD HISTORY

How does your child occupy his/her time? _____

_____

Has your child ever participated in team sports or other competitive sports?

If yes, which ones? _____

How does your child perform athletically? _____

SLEEP

What time does your child typically go to bed? _____ Arise? _____

Does your child have any of the following:

- trouble falling asleep ☐yes ☐no
- trouble staying asleep through the night ☐yes ☐no
- sleepwalking ☐yes ☐no
- snoring ☐yes ☐no
- nightmares ☐yes ☐no
- excessive movement (such as “restless legs”) ☐yes ☐no

CONDITIONS

Please check the following diseases or conditions your child has had:

Anemia	☐	Encephalitis	☐	Mumps	☐
Asthma	☐	Enzyme deficiency	☐	Oxygen deprivation	☐
Bleeding disorder	☐	Genetic disorder	☐	Pneumonia	☐
Blood disorder	☐	Heart disorder	☐	Rheumatic fever	☐
Brain stroke	☐	Kidney disorder	☐	Scarlet fever	☐
Broken bones	☐	Leukemia	☐	Tuberculosis	☐
Cancer	☐	Lung disorder	☐	Whooping cough	☐
Chicken pox	☐	Measles	☐	Other:	
Colds (excessive)	☐	Metabolic disorder	☐		

INTERVENTION HISTORY

List any medications your child is currently taking:

NAME(S)	DOSAGE	REASON

List any medications your child has taken in the past for more than a month:

NAME(S)	DOSAGE	REASON

Has your child ever had a bad reaction to any medication? ☐yes ☐no

If yes, describe: _____

Has your child received any psychological or psychiatric treatment? ☐yes ☐no

If yes, when and by whom? _____

_____

Please list all of the doctors, therapists, and other providers treating your child right now:

NAME	SPECIALTY

Please check therapies have been provided to your child:

No therapies	☐	Speech therapy	☐
Occupational therapy	☐	Chiropractic treatment	☐
Physical therapy	☐	Vision therapy	☐
Psychological therapy	☐	Biofeedback	☐
Cognitive rehabilitation	☐	Homeopathic treatment	☐

BEHAVIOR & SOCIAL HISTORY

Does your child…

have difficulty getting along with other children his/her own age? ☐yes ☐no
have difficulty getting along with adults? ☐yes ☐no
have problems making friends in school? ☐yes ☐no
have problems getting along with teachers? ☐yes ☐no
get sick in the morning before school? ☐yes ☐no
get disciplined frequently at school? ☐yes ☐no
have emotional, adjustment, or behavioral problems? ☐yes ☐no

SCHOOL HISTORY

Does your child like school? ☐yes ☐no

Did your child attend nursery school or a preschool program? ☐yes ☐no Age started: _____

Were there any problems? ☐yes ☐no If yes, describe: _____

Did your child attend kindergarten? ☐yes ☐no Age started: _____

Were there any problems? ☐yes ☐no If yes, describe: _____

Did your child attend 1st grade? ☐yes ☐no Age started: _____

Were there any problems? ☐yes ☐no If yes, describe: _____

Has the school currently reported problems with:

reading	☐	arithmetic	☐	following directions	☐
spelling	☐	attention span	☐	social adjustment	☐
writing	☐	behavior	☐		

Has any psychological testing been done at school? ☐yes ☐no

If so, where, when, and by whom? _____

What recommendations were made? _____

Has your child ever been held back or repeated a grade?

If so, for which grade(s) and for what reason(s)? _____

Does your child receive any special services in school? (placement in special classroom, tutoring, reading, OT, speech, etc…) ☐yes ☐no

If yes, what services and for how long? _____

If not now, has your child ever been in a special class or provided services under an individualized education plan (IEP) or 504 plan? ☐yes ☐no

If yes, describe: _____

Have you ever privately obtained any academic help for your child? ☐yes ☐no

If yes, indicate what type, by whom, and how often: _____

What grades has your child typically received in the past year?

A's & B's	☐	Outstanding	☐
B's & C's	☐	Good	☐
C's & D's	☐	Satisfactory	☐
D's & F's	☐	Improvement Needed	☐
		Unsatisfactory	☐

Are these grades consistent with previous years? ☐yes ☐no

In what subject does your child do best? _____ Have the most difficulty? _____

In the past year has your child been absent…

less than 2 weeks ☐ 2 – 4 weeks ☐ 5 – 8 weeks ☐ 8+ weeks ☐

Briefly describe the reasons for your child's absence(s): _____

_____

Additional comments: