CHILDHOOD HISTORY FORM

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Child's Name:_____

Child's Home Address: _____

_____ Sex:_____ Birth Date:_____ Age:_____

Home Phone: _____ Cell Phone: _____

Email address:_____

Child's School:_____ Grade:_____

Special Placement (if any):_____ Bilingual? ☐ Yes ☐ No

Primary language in the home: _____ Ethnic Background:_____

Child is presently living with: ☐ Birth Mother ☐ Birth Father ☐ Stepmother ☐ Stepfather

☐ Adoptive Mother ☐ Adoptive Father ☐ Other (Specify):_____

Who else regularly provides care for your child? _____

Does your child have regular visitation with a non-custodial parent? ☐ Yes ☐ No If so, what is the schedule? _____

Source of Referral:_____

Who is your family doctor or physician? _____

When was your child's last physical examination?_____

Current physical problems or symptoms:_____

_____

Is your child taking any medications? ☐ Yes ☐ No If so, Please list them:_____

_____

Past medications:_____

Has your child had any serious illnesses, accidents, operations or been hospitalized?_____

_____

_____

Please list your main concerns in order of importance: _____

_____

_____

Please list any specific questions you would like answered:

_____

_____

_____

Please list your child's main hobbies, interests, strengths and community activities: _____

_____

_____

_____

Hours your child spends with the following each day? _____TV _____ Xbox/Wii/Video Gaming _____Internet

FAMILY AND SOCIAL HISTORY

FATHER: Name: _____ Age: _____

Address: _____

_____ Phone: _____

Highest Grade Completed: _____ Occupation: _____

Describe quality of relationship: _____

MOTHER: Name: _____ Age: _____

Address: _____

_____ Phone: _____

Highest Grade Completed: _____ Occupation: _____

Describe quality of relationship: _____

SIBLINGS/OTHER HOUSEHOLD MEMBERS: Names: _____

Ages: _____ General Health: _____

Describe quality of relationship: _____

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Ages: _____ General Health: _____

Describe quality of relationship: _____

FAMILY HISTORY	CHILD'S MOTHER	CHILD'S FATHER	CHILD'S BROTHER(S)	CHILD'S SISTER(S)	OTHERS
Concentration/Attention Problems	☐	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐	☐
Trouble Learning	☐	☐	☐	☐	☐
Behavior Problems in Childhood	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Other Mental Illness	☐	☐	☐	☐	☐
Drinking Problems or Drug Abuse	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐
Tics/Nervous Habits	☐	☐	☐	☐	☐
Obsessions	☐	☐	☐	☐	☐
Mood Swings	☐	☐	☐	☐	☐
Anger Problems	☐	☐	☐	☐	☐

Please list any significant stressors, such as moving, illness, divorce, losses, separation from parents, or domestic violence: _____

_____

_____

_____

Has child ever experienced: ☐ Sexual Abuse ☐ Physical Abuse ☐ Emotional Abuse ☐ Neglect

Have you suspected or ever worried about your child being harmed in any other way?_____

_____

_____

_____

_____

Describe the types of discipline that you have used with your child and how effective they have been: _____

_____

_____

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

_____

_____

PEER RELATIONSHIPS

Does your child have problems making/keeping friends? _____

Does your child play with other children the same age? _____

Younger? _____ Older? _____

Briefly describe any problems your child may have with peers. _____

_____

How does your child get along with other family members?_____

_____

MEDICAL AND DEVELOPMENTAL HISTORY

PREGNANCY

While you were pregnant with this child, were you under a doctor's care? ☐ Yes ☐ No

Describe any medical, emotional or substance use issues during pregnancy (please include any medications used during pregnancy). _____

_____

_____

_____

BIRTH HISTORY Mother's age at time of birth: _____ Father's age at time of birth: _____

Did mother smoke during pregnancy? ☐ Yes ☐ No

Drink Alcohol? ☐ Yes ☐ No

What did the baby weigh?: _____

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How many hours from first contractions to birth?:_____

Were you given medication or anesthesia?: ☐ Yes ☐ No

If yes, please describe: _____

Was the delivery unusual in any way? ☐ Yes ☐ No If yes, please describe: _____

_____

Did you have a Cesarean? ☐ Yes ☐ No If yes, any complications?: _____

Did this baby have: breathing problems? ☐ Yes ☐ No Cord around neck? ☐ Yes ☐ No

Was this baby's color normal? ☐ Yes ☐ No ☐ Blue ☐ Yellow ☐ Don't Know

Was oxygen used for this baby? ☐ Yes ☐ No ☐ Don't Know How Long? _____

Was the baby premature or late? ☐ Yes ☐ No How much? _____

Did you take the baby home with you from the hospital? ☐ Yes ☐ No How long after delivery? _____

Please describe any problems this baby had during the first few months of life (e.g. feeding, colic, activity):

_____

_____

MEDICAL HISTORY OF CHILD: Has your child had any of the following?

Check all that apply	Age
☐ Measles	
☐ Chicken Pox	
☐ Flu	
☐ Diphtheria	
☐ Ear Infection	
☐ Head Injuries	
☐ Sleep Problems	
☐ Soiling	
☐ Headaches	

Check all that apply	Age
☐ German measles	
☐ Whooping Cough	
☐ Strep Throat	
☐ High Fever	
☐ Tubes in Ears	
☐ Asthma	
☐ Vomiting	
☐ Allergies	
☐ Other _____	

Check all that apply	Age
☐ Mumps	
☐ Hearing Problems	
☐ Meningitis	
☐ Encephalitis	
☐ Seizures	
☐ Vision Problems	
☐ Wetting	
☐ Other Injuries	
☐ Other _____	

Is your child involved with street drugs or alcohol? ☐ Yes ☐ No

If yes, please describe: _____

Age of menstruation (if applicable): _____ Problems? ☐ Yes ☐ No

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Has this child been sexually active? ☐ Yes ☐ No If yes,

please describe: _____

DEVELOPMENTAL HISTORY: (Answer as best you can remember)

Motor Development (Sitting, Crawling, Walking):	☐ Early	☐ Normal	☐ Delayed
Speech & Language:	☐ Early	☐ Normal	☐ Delayed
Self-help Skills (Dressing, Brushing, Shoe tying):	☐ Early	☐ Normal	☐ Delayed
Toilet Training:	☐ Early	☐ Normal	☐ Delayed
Handedness:	☐ Left	☐ Right	☐ Both
Eating Behavior	☐ Overeats sugar/carbs	☐ Eats too much	☐ Picky

SENSORY CONCERNS: Is your child sensitive to, or do they display, any of the following?:

☐ Light	☐ Touch	☐ Rocking
☐ Head banging	☐ Sounds	☐ Textures
☐ Falling Spells	☐ Sock seams/tags	☐ Food textures/aversions

TEMPERAMENT (Infancy, Toddler, Preschool): Check any that apply.

☐ Shy or Timid	☐ Fearful	☐ Impulsive	☐ Stubborn
☐ Easy to Manage	☐ Aggressive	☐ Affectionate	☐ Social
☐ Easy-going	☐ Outgoing	☐ Underactive	☐ Slow to warm-up
☐ Curious	☐ Into Everything	☐ Overactive	☐ Temper Outbursts
☐ Destructive	☐ Happy	☐ Daredevil	☐ Wanting to be left alone
☐ More interest in things than people		☐ Other(s) _____	

SCHOOL HISTORY Do you believe your child understands directions and interprets situations as well as other children his or her age? _____

If not, please describe: _____

How would you rate your child's overall level of intelligence compared to other children? ☐ Below Average ☐ Average ☐ Above Average Additional Comments: _____

_____

Please list previous psychological/academic evaluations (please provide copies): _____

_____

To the best of your knowledge, at what grade level is your child functioning?

Reading:	☐ Below grade level	☐ On grade level	☐ Above grade level
Spelling:	☐ Below grade level	☐ On grade level	☐ Above grade level
Writing:	☐ Below grade level	☐ On grade level	☐ Above grade level
Arithmetic:	☐ Below grade level	☐ On grade level	☐ Above grade level

Has your child ever repeated a grade? _____ If so, when? _____

As best you can recall, please use the following space to provide a general description of your child's school progress, including schools attended. Use the back of this form if extra space is needed. Please attach samples of report cards or yearly testing.

_____

_____

_____

_____

_____

_____

Has your child ever received any of the following?

		☐ Tutoring	☐ Speech/Language Therapy
☐ Counseling	☐ One-to-one Aid	☐ PT	☐ Remedial Services
☐ Special Education	☐ Gifted Testing	☐ OT	☐ Individual Edu. plan (IEP)
☐ 504 Accommodation plan	☐ Other (Describe) _____		

Are there any other risk issues, self-harm, or safety concerns?: _____

_____

Signed: _____

Relationship to Child:_____

Date:_____

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