Child's History

The following questions are asked so that we can best understand your child. Please fill out this questionnaire before the child is evaluated. Please read the questions carefully and answer them as fully as possible. Use the back of the sheet if necessary. If there are any questions you don't understand, these can be filled out with the examiner's help when she reviews the history with you. Please star (*) such questions.

Child's Information

Legal name _____ Birth Date _____ Age _____

Home Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Child's Doctor _____ Phone _____

What are the problems which caused you to seek help for this child? _____

_____

Family History

Child is living with:

☐ Both parents ☐ Mother ☐ Father ☐ Mother and Stepfather
☐ Father and stepmother ☐ Legal Guardian ☐ Other (please specify) _____

Is the child adopted ? ☐ Yes ☐ No If yes, with which parent (s) (if any) does the child live?
☐ natural ☐ adoptive Child's age at adoption? _____

Status of parent's marriage:
☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single
How long married? _____How Long Divorced? _____Child's age at divorce _____

	Birth Mother	**Birth Father**
Age:	_____	_____
Highest grade completed	_____	_____
Diploma/Degree	_____	_____
Occupation	_____	_____

Please describe any special education or tutoring in parent:

_____ _____

Please describe any grade repeated or subjects failed:

_____ _____

Please describe any learning difficulty and subject and grade level at which it occurred:

_____ _____

Please describe any behavior problems and treatment received:

_____ _____

Please describe any psychological or psychiatric problems for which treatment was received:

_____ _____

Any Attention-Deficit Disorder or hyperactivity? Please describe treatment:

_____ _____

Adoptive Mother or Stepmother or Other (circle one)

Age: _____
Highest grade completed: _____
Diploma/Degree _____
Occupation: _____
Please describe any psychological or psychiatric problems for which treatment was received:

_____

Adoptive Father or Stepfather or Other (circle one)

_____
_____
_____
_____

_____

Other Children
(Includes step-siblings and half-siblings)

Name Age Sex In Home? School/behavior/health problems

_____

_____

Biological Extended Family

Do any extended family members (maternal/paternal grandparents, uncles, aunts, cousins) suffer from a problem with inattentiveness or hyperactivity, epilepsy, seizures, migraines, alcoholism or substance-abuse, psychological, emotional, or personality difficulty, learning problems or developmental disabilities, and/or a " nervous" or neurological disorder, etc.?
☐ Yes ☐ No If yes, please list relationship to child, disorder, and any treatment received.

Maternal (mother's side) **Paternal (father's side)**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Birth and Developmental History

Pregnancy

Length in months _____ Any illnesses or complications while pregnant? ☐ Yes ☐ No

If yes, explain. _____

Medication taken by the mother **during** pregnancy?_____

Substances used **during** pregnancy?

☐ Cigarettes How many? _____ per (☐ day ☐ week)

☐ Alcohol How many drinks? _____ per (☐ day ☐ week ☐ month)

☐ Drugs Please describe type(s) of drug, frequency of use, and at what month of pregnancy use was stopped (if applicable).

_____

Was the father taking any medications or drugs at time of conception? If so, what?

_____

How many pregnancies and/or miscarriages has the mother had? _____

Labor and Delivery

Was the birth of the child "normal"? ☐ Yes ☐ No If no, please explain.

_____

_____

Do you think the child's problems might be related to pregnancy, labor, or delivery?

☐ Yes ☐ No If no, please explain.

_____

_____

Perinatal History

Birth Weight _____ Length _____ Apgar Score(s) _____

Did mother or baby stay in Special or Intensive Care? ☐ Yes ☐ No Please describe any problems. _____

_____

Please list any birth defects. _____

Infancy and Early Childhood

Please rate the child on the following behaviors: Circle 1 if 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. tanrums and headbanging), please check the one that was present.

quiet and contented	1	2	3	4	5	colicky and irritable
very easy to feed	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 ☐ headbanging
cautious and careful	1	2	3	4	5	☐ accident prone ☐ dare devil
coordinated	1	2	3	4	5	uncoordinated
enjoyed eye contact	1	2	3	4	5	avoided eye contact
liked other people	1	2	3	4	5	disliked contact with people

Other problems or comments regarding infancy or early childhood development

_____

_____

Did any event, health condition, separation, etc. disturb early infant/mother bonding or developing toddler/mother relationship? ☐ Yes ☐ No If yes, explain.

_____

_____

Please describe the child as an infant (temperament, sleeping, eating patterns, etc.)

_____

_____

Ages at Milestones

Gross motor: crawled _____ walked alone _____ ran well _____

Fine motor: fed self with spoon _____ scribbled _____ tied shoes _____

Language: used single words _____ used sentences(2+ words)_____

Described activity in words _____

Social/Adaptive: potty trained/day _____ potty trained/night _____

Rate of development overall: ☐ Slow ☐ Normal ☐ Fast

Medical History

Has the child been taken to the emergency room, hospitalized, or had outpatient surgery since birth? ☐ Yes ☐ No If yes, please describe condition/injury, treatment, surgery, when, how long, and where.

_____

_____

_____

_____

Did the child suffer from a fall or other injury resulting in a blow to the head? ☐ Yes ☐ No If yes, please describe circumstance. _____

_____

Did he or she lose consciousness? ☐ Yes ☐ No If so, how long? _____ Any change in personality following the injury? ☐ Yes ☐ No If yes, please describe. _____

_____

Was he or she comatose? ☐ Yes ☐ No If so, for how long? _____

Has the child run exceptionally high fevers or experienced one or more febrile seizures? ☐ Yes ☐ No If yes, please describe. _____

Has the child been tested and found to have allergies? **Food** ☐ Yes ☐ No **Respiratory** ☐ Yes ☐ No If yes, please describe. _____

_____

If not, do you suspect that the child may have allergies and that these are contributing to the symptoms presented? ☐ Yes ☐ No If yes, please describe. _____

Is there any family history of allergies (biological mother, father, siblings)? ☐ Yes ☐ No If yes, please describe. _____

Do you suspect or has the child ever been diagnosed with Lyme Disease? ☐ Yes ☐ No If yes, when was the child first exposed (age, date)? _____ How was the diagnosis made and by whom?

_____

How long after contracting the disease was the child treated, and what type of treatment?

_____

What symptoms has the child presented and when? _____

_____

Has the child been diagnosed with any other specific medical condition? ☐Yes ☐No If yes, please describe (Condition, when diagnosed, by whom). _____

Has the child experienced frequent ear infections? ☐ Yes ☐ No If yes, did this require tubes being placed in the ears? ☐ Yes ☐ No If yes, when? _____

Did the child have a hearing test at that time? ☐ Yes ☐ No If yes, were the results normal? ☐ Yes ☐ No

Date of last hearing exam?_____ Were the results normal? ☐ Yes ☐ No

Date of last vision exam? _____ Does the child wear ☐ glasses? ☐ contacts?

Why? _____

Please list medications (with dosage and times) currently being taken by the child, including nonprescription medication. _____

_____

_____

The child's current health is: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Behavioral and Mental Health History

Do you see the child as being ☐ hyperactive? ☐ inattentive? ☐ a behavior problem?

Does the child seem to be able to control his or her behavior? ☐ Yes ☐ No Please explain.

_____

_____

Please describe any behaviors that are particularly concerning to you or others.

_____

_____

_____

_____

Please list any unusual, traumatic, or possibly stressful events in the child's life that you think may have had an impact on his or her development and current functioning. Include incident, child's age at the time, and comments.

_____

_____

_____

_____

_____

Has the child or family received any professional mental health treatment, such as individual or family counseling, group counseling, etc.? ☐ Yes ☐ No Please list any past and current treatments, including type of counseling, person counseled, name of counselor, and length of treatment.

_____

_____

_____

Present Personality and Behavior

Please circle all traits that apply to the child now:

sad happy leader follower moody

friendly quiet overactive independent dependent

sensitive affectionate fearful cooperative tantrums

lethargic too responsible trouble sleeping hard to discipline

even-tempered prefers to be alone

Educational History

Did the child attend preschool or daycare? If so, list location, type of program, number of days per week, age when started, progress. _____

_____

_____

Current grade and school _____

Was the child ever classified by the school district? ☐ Yes ☐ No If so, in what grade did this occur and what was the classification? _____

If the child was not classified, does he or she have a 504 Plan with accommodations to meet his/her specific educational needs? ☐ Yes ☐ No If yes, give date of 504 Plan _____

List previous schools and grades attended at each. _____

_____

Briefly describe the child's performance and any concerns in each grade:

Kindergarten_____

1st grade _____

2nd grade _____

3rd grade _____

4th grade _____

5th grade _____

6th grade _____

7th grade _____

8th grade _____

High School

9th grade _____

10th grade _____

11th grade _____

12th grade _____

What type of special education classes, in class support, resource room, special services (speech therapy, occupational therapy, social skills groups, etc.) has the child received? State type of support given and grade(s) in which this occurred:

_____

_____

_____

Additional Information

Please attach results of any previous individual testing, standardized tests, grade reports, teachers' comments (**copies only**).

Please add any additional comments you think might be helpful.

_____

_____

_____

_____

_____

Signature: _____ _____

Individual completing form, relationship to child Date