

# 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, they can be filled out with the examiner's help when he or 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 that 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 parents' marriage:  Married How long married? \_\_\_\_\_

Separated  Divorced How long divorced? \_\_\_\_\_ Child's age at divorce: \_\_\_\_\_

Widowed  Single

### *Birth Mother*

### *Birth Father*

Age: \_\_\_\_\_

\_\_\_\_\_

Highest grade completed: \_\_\_\_\_

\_\_\_\_\_

Diploma/Degree: \_\_\_\_\_

\_\_\_\_\_

Occupation: \_\_\_\_\_

\_\_\_\_\_

Please describe any special education or tutoring:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please describe any grades repeated or subjects failed:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Birth Mother**

**Birth Father**

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/Stepmother/Other**  
(circle one)

**Adoptive Father/Stepfather/Other**  
(circle one)

Age: \_\_\_\_\_

\_\_\_\_\_

Highest grade completed: \_\_\_\_\_

\_\_\_\_\_

Occupation: \_\_\_\_\_

\_\_\_\_\_

**Other Children (including step-siblings and half-siblings)**

Name	Sex	Age	In home?	School/behavioral/health problems
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**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)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please provide any other information about the child's extended family that might help us understand the child's needs (medical, developmental, behavioral, educational, emotional, or psychological). \_\_\_\_\_

\_\_\_\_\_

## Birth and Developmental History

### *Pregnancy*

Length in months: \_\_\_\_\_

Any illnesses or complications while pregnant?  Yes  No If yes, please explain: \_\_\_\_\_

Medications 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?  Yes  No 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 yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

### *Perinatal History*

Birth weight \_\_\_\_\_ Length \_\_\_\_\_ APGAR scores \_\_\_\_\_

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 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 and head banging), please check the one that was present.

quiet and content	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	<input type="checkbox"/> tantrums <input type="checkbox"/> head banging
cautious and careful	1	2	3	4	5	<input type="checkbox"/> accident prone <input type="checkbox"/> 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

Other problems or comments regarding infancy or early childhood development: \_\_\_\_\_

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

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

### Ages at Milestones

Gross Motor Skill	Age	Language Skill	Age
crawled	_____	used single words	_____
walked alone	_____	used sentences (2+ words)	_____
ran well	_____	described activity	_____
Fine Motor Skill	Age	Social/Adaptive Skill	Age
fed self with spoon	_____	potty trained/day	_____
scribbled	_____	potty trained/night	_____
tied shoe	_____		

Rate of development overall:  Slow  Normal  Fast

## Medical History

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

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If the child had a head injury: Did he or she lose consciousness?  Yes  No

If yes, how long? \_\_\_\_\_

Was he or she comatose?  Yes  No If yes, how long? \_\_\_\_\_

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 and attention?

Yes  No If no, please explain: \_\_\_\_\_

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Has the child ever been diagnosed by a psychologist, physician, or other professional as having ADHD (Attention-Deficit/Hyperactivity Disorder)  Yes  No

If yes, when? \_\_\_\_\_

What treatment has the child had for ADHD (other than medications)? \_\_\_\_\_

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What medication(s) has the child received for ADHD (include dosage and times)? \_\_\_\_\_

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Please describe any other handicapping conditions or special health considerations and their treatments: \_\_\_\_\_

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Date of last hearing test: \_\_\_\_\_ Were the results normal?  Yes  No

If no, please explain: \_\_\_\_\_

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Date of last vision test: \_\_\_\_\_ Does the child wear  Glasses?  Contacts?

Why? \_\_\_\_\_

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

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

## Behavioral and Mental Health History

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

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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:

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

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### *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, and progress: \_\_\_\_\_

Current grade and school: \_\_\_\_\_

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: \_\_\_\_\_

Middle School: \_\_\_\_\_

High School

Has the child been placed in special education programs currently or in the past?

Yes  No If yes, please describe:

Category: \_\_\_\_\_

Learning Disability (LD): \_\_\_\_\_  
(subjects)

Language Disorder: \_\_\_\_\_  
(type)

Tutoring: \_\_\_\_\_  
(subjects)

**Additional Information**

Please attach results of any previous testing.

Please add any additional comments you think might be helpful.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Individual completing form, relationship to child*