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CHILD & ADOLESCENT HISTORY FORM

Instructions to parents: Please fill out to the best of your knowledge. Write N.A. if not applicable to your child. Circle appropriate answers where indicated. Continue on back of pages if necessary and add any additional comments you wish to make.

Date_________________

Child's Name: _______________________________________Child's Age: ______ Date of Birth:___________________

Home Address:____

Sex (circle): Male Female Grade in School: _________ Handedness (circle): Right Left

Race/Ethnicity:_____________________________________Religion:____

Child's Primary Language:__________________________ Child's Secondary Language:__________________________

Name of person filling out this form: __________________________Relationship to child: _____________________

Caregiver/Parent Home Phone: ______________________________ Caregiver/Parent Work Phone: __________________

Name of person who referred your child to us: ____

Is this evaluation related to any legal matters or actions? No Yes If yes, please explain:________________________

Please describe your main goal(s) for this evaluation (e.g., what do you hope to learn?):

____

____

____

Chief Complaint
Please list your main complaint(s) or concern(s) for your child:

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____

Child's Education

Name of current school: ____

Address of current school:____

Names of Schools attended	Grade Numbers	Any Difficulties?		Comments
		No	Yes	

Child's Education

Has your child been retained or held back for any grades? No Yes

If yes, what grade(s): ___________ And describe reason why: ___________________________________

____

Has your child missed many days of school in the past? No Yes

If yes, why and how much time absent? ____

Has any psychological or educational testing been done in the school? No Yes

What were the results? ____

How would you describe your child's intellectual abilities? (circle)

Delayed Below Average Average High Average Superior

What special services has your child received in the school?

	Please check		If yes, age and/or grade **when started?**	Does he/she still get this service?		If still receives service, **how often**?	If stopped, age and/or grade **when stopped?**	Comments
	No	**Yes**		**No**	**Yes**			
Resource room								
Remedial reading								
Tutoring								
Study skills training								
Social skills group								
Special education classroom								Type of Classroom Setting:
Speech therapy								
One-on-one aide								
Occupational therapy								
Physical therapy								
Psychology services								
Social work services								
Other (identify)								

What special services has your child received in the in the community, hospital, or home?								
	Please check		**If yes,** age and/or grade **when started?**	Does he/she still get this service?		If still receives service, **how often**?	If stopped, age and/or grade **when stopped?**	Comments
	No	**Yes**		**No**	**Yes**			
Tutoring								
Speech therapy								
Occupational therapy								
Physical therapy								
Social skills group								
Psychology services								
Social work services								
Psychiatry services								

Pregnancy and Developmental History

Pregnancies – List in order of birth, including the child to be seen.
If ended in miscarriage, state and which month and why, if known.

Year	Length of Pregnancy	Birth Weight	Sex	Complications
___________	__________________	____________	_____	_____________________________________
___________	__________________	____________	_____	_____________________________________
___________	__________________	____________	_____	_____________________________________

Was this child adopted? No Yes If yes, age at time of adoption: ______________________

Pregnancy with this child – (check appropriate answer)

	No	Yes	Don't Know	When?	Comments
Anemia					
High blood pressure					
Toxemia					
Kidney disease					
Heart disease					
Bleeding					
German measles					
Virus					
Diabetes					
Rh incompatibility					
Hospitalization					
Operation					
Injury					
Threatened miscarriage					
Prescription medication					
Did you smoke?					How much?
Did you drink?					How much?
Did you use illicit drugs?					What and how often?
Other (identify)					

Birth History- (check appropriate answer)

	No	Yes	Don't Know	When?	Comments
Was this baby premature?					How much?
Was the baby delivered vaginally?					
Where there any complications during delivery?					Explain:
Were any instruments needed to assist with delivery? (e.g., forceps, vacuum extractor)					Please specify:
Did the baby have any complications after delivery?					Explain:
Did you experience the baby blues after delivery?					
What were the baby's Apgar scores? (scale of 0-10: 1 & 5 minutes)					
Did you experience postpartum depression after delivery?					
Other (identify)					

Development

Was this child any different from his/her brother(s) or sister(s)? No Yes

How? ____

How would you describe this child's temperament as an infant? (Circle all that apply)

Easy to soothe Regular patterns of sleeping and eating Colicky Difficult to soothe Irregular Slow to warm up

Other (please describe): ____

Please provide the approximate age the following <u>developmental milestones</u> were achieved.

Note any difficulties achieving these milestones.

	Age in Months	Age in Years	Not Yet Accomplished	Comments
Motor				
Rolled over				
Sat alone				
Walked without holding on				
Fed self				
Scribbled with crayon/pencil				
Dressed self				
Tied shoes				
Pedaled tricycle				
Rode bicycle				
Swam				
Language				
Spoke first words				
Used 2-3 words together				
Used good sentence structure				
Cognitive				
Named colors				
Learned the alphabet				
Count				
Toileting				
Trained for urine (daytime)				
Trained for urine (nighttime)				
Trained for bowels				

Past Medical and Surgical History

Has your child had any of the following (check "No" or "Yes" and give the approximate year of onset):

	No	Yes	Onset	Diagnosis	Comments
Allergic illness					
Anemia					
Anoxia/Hypoxia					
Asthma					
Bedwetting problem					
Cancer or tumor					
Cerebral palsy					
Diabetes					
Encephalitis					
Frequent ear infections					
Head injury					
Hearing impairment					
Heart disease or murmur					
High fever					
Lead poisoning/toxic ingestion					
Loss of consciousness					

Past Medical and Surgical History

Has your child had any of the following (check "No" or "Yes" and give the approximate year of onset):

	No	Yes	Onset	Diagnosis	Comments
Meningitis					
Rheumatoid arthritis					
Seizure or epilepsy					
Sleep disorder					
Tonsils/Adenoids removed					
Vision Problems					
Any other medical problems not described above? (identify)					

List any operations, hospitalizations, or special treatments, your child has had (describe & give dates)

Operations	Date	**Other hospitalizations** (describe)	Date

Has your child ever been seriously injured? (If so, describe and give date)___________________________________

____

Please list any known allergies

Seasonal allergies (hay fever, etc.) ____

Medication allergies or sensitivities ____

Please review the following list of specialists and procedures and identify who has been consulted or which tests have been performed and the approximate date

	No	Yes	Date	Diagnosis	Comments
Mental health specialist					
Neurologist					
Other specialist					
Eye exam done?					
Hearing exam done?					
EEG done?					
Neuroimaging studies done? (CT, MRI, PET, etc.)					
Neuropsychological testing done?					
Other tests done? (identify)					

Is your child <u>currently</u> taking any medications? Yes No If yes, please fill in below information:

Medication Name	**Dose**	**When started?**	**What is it for?**
1.			
2.			
3.			
4.			
5.			

6.			

List additional medications <u>used in the past, regularly</u>				
Medication Name	**Dose**	**When started?**	**When stopped?**	**What was it for?**
1.				
2.				
3.				
4.				
5.				

Social and Emotional History

Please check "No" or "Yes" for the following questions	No	Yes
Are there any significant marital conflicts?		
Are there any significant conflicts between child and parents?		
Are there any significant conflicts between the children?		
Does the child have difficulty getting along with children his/her own age?		
Does the child have difficulty keeping friends?		
Does the child have difficulty getting along with other adults?		
Do the parents agree on how to discipline the child?		

Please answer the following questions below:

Who disciplines and how? ____

____

How does the child respond to discipline? ____

____

What special interests or skills does the child have? ____

____

How does the child perform athletically? ____

____

What are your favorite things about your child? ____

____

What is the most difficult thing(s) about caring for your child? ____

____

List all the moves during the child's lifetime and describe any problems relating to adjusting to the new home, neighborhood, or school. Give age of child for each move.

Age at Move	Moving from where to where?	Any problems adjusting?

Have there been any prolonged separations from one or both parents for the child? List each, describing the reason for the separation, length of time, and age of child when the separation took place.

Age	Length of time	Reason for separation

Please answer the following questions below:

Has the child ever been involved with the law or experienced any legal difficulties? ________________________________

____

Is there any history of verbal, physical, and/or sexual abuse for the child? ____

____

Has your child ever tried to harm or injure himself/herself? No Yes

Has your child ever thought about suicide or attempted to kill himself/herself? No Yes

Has your child ever tried to seriously harm or injure another person? No Yes

To your knowledge, has your child:

	Smoked cigarettes	No	Yes
	Used alcohol	No	Yes
	Abused prescription medication	No	Yes
	Used illicit drugs	No	Yes

Has your child ever had an inpatient psychiatric hospitalization? No Yes (If yes, how many times? _______)

If yes, when? ______________________ where?________________________ primary reason?_____________________

Is the child's problem getting worse? No Yes

Is there anything else that is important to know about your child? ____

____

____

____

Family History

Parents are (*circle*): living together separated divorced deceased (one or both) other:___________

If separated, divorced, or deceased:

When? _________ Age of child? ______________________ Who has custody? ________________________________

How often does each parent see child? ____

Who is the child currently child living with? (*Circle all that apply)*

Biological Mother Biological Father Step-Mother Step-Father Adoptive Mother Adoptive Father

Legal Guardian Other Adults (Specify): ____

Sisters (how many? ______) Brothers (how many?__________)

Other children (specify): ______________________________
What language(s) is spoken in the home? ______________________________