

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
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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
crawled	_____
walked alone	_____
ran well	_____

Fine Motor Skill

	Age
fed self with spoon	_____
scribbled	_____
tied shoe	_____

Language Skill

	Age
used single words	_____
used sentences (2+ words)	_____
described activity	_____

Social/Adaptive Skill

	Age
potty trained/day	_____
potty trained/night	_____

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:

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: _____

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)? _____

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

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

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

If no, please explain: _____

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):

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:

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 If yes, 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, 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:

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