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PEDIATRIC HISTORY FORM (for Parent/Guardian to complete before appointment)

The following questions are being asked to help us better understand your child. Please fill out this form before your child's appointment, and bring it with you on the day of the appointment. Please read the questions carefully and answer them as fully as possible.

Are there parts of this form that **should not be** discussed in front of your child? ☐**Yes** ☐**No**

Date form was completed: _____

Name of person filling out form: _____ Your relationship to child: _____ Phone #: _____

CHILD'S INFORMATION:

Child's name:_____ Age: ____ Date of Birth:_____ Sex: ☐M ☐F ☐Other

Mailing Address: _____

City: _____ State: _____ Zip: _____ Home Phone #:_____

This child is: ☐Right- handed ☐Left-handed ☐Unsure

Has this child been tested in the last 12 months (for example, for special education, speech and language, or developmental issues)? ☐No ☐Yes

REFERRAL INFORMATION:

Please describe as fully as you can why this child is being brought for evaluation. If he/she has a medical condition that may be contributing to his/her problems (e.g., head injury, seizures, brain tumor), please include what happened, when it happened, type of treatment provided, etc.

_____

_____

_____

FAMILY INFORMATION:

	Birth Mother	Birth Father
Name:	_____	_____
Age:	_____	_____
Highest grade finished:	_____	_____
Current Job:	_____	_____
Home Address:	_____	_____
Phone Number:	_____	_____

Status of parents' relationship: ☐Married ☐Separated ☐Divorced ☐Never married ☐One or both parents died

With whom does the child live?

_____

CULTURE/BACKGROUND/IDENTITY:

	Child	Birth Mother	Birth Father
Ethnicity			
1. Hispanic or Latino	☐	☐	☐
2. Not Hispanic or Latino	☐	☐	☐
3. Unknown	☐	☐	☐
Race			
a. African-American or Black	☐	☐	☐
b. Asian	☐	☐	☐
c. White	☐	☐	☐
d. Native American or Alaskan Native	☐	☐	☐
e. Native Hawaiian or Pacific Islander	☐	☐	☐
f. Other: _____	☐	☐	☐
f. Unknown	☐	☐	☐

What is the **main language** spoken in the home? ☐English ☐Spanish Other:_____

Does **this child** speak a language other than English? ☐No ☐Yes

If yes, what language(s)?_____ At what age did this child start speaking this language?_____

CHILD/FAMILY HISTORY

Please indicate if the child or any immediate family members (siblings, parents, or grandparents) have or have had any of the following:

	Child	**Family Member (check box** and write **which family member** next to it)
Psychiatric problems		
Anxiety or phobias	☐	☐
Depression	☐	☐
Bipolar disorder (manic-depression)	☐	☐
Schizophrenia	☐	☐
Suicide	☐	☐
Alcoholism	☐	☐
Drug abuse	☐	☐
Neurodevelopmental problems		
Autism spectrum disorder	☐	☐
Attention deficit disorder/hyperactivity (ADHD)	☐	☐
Learning disability (reading, writing, math)	☐	☐
Intellectual disability (mental retardation)	☐	☐
Language or Speech problem	☐	☐
Medical/Neurological problems		
Cerebral palsy	☐	☐
Epilepsy (seizures, convulsions)	☐	☐
Genetic Disorders	☐	☐
Stroke	☐	☐
Cancer	☐	☐

PREGNANCY AND DELIVERY:

Mother's age at pregnancy of this child: _____ Father's age at pregnancy of this child: _____

When did prenatal care begin with this child? _____

Mother's health during the pregnancy: ☐Excellent ☐Fair ☐Poor

Please check any of the following that the child's **mother** had during the pregnancy:

☐Measles	☐Excessive swelling	☐Emotional problems
☐German measles	☐Excessive vomiting	☐Injury or accident
☐High fever	☐Poor nutrition	☐Placenta abrupta
☐High blood pressure	☐Abnormal weight gain	☐Placenta previa
☐Toxemia/Pre-eclampsia	☐Diabetes	☐X-rays (in what month? _____)

☐**Other medical conditions mother experienced during pregnancy**:_____

☐**Hospitalizations/surgeries during pregnancy** If yes, please describe: _____

☐**Took medications during pregnancy** If yes, please describe _____

Substances used during pregnancy:	**Amount/Frequency:**	**Trimester of pregnancy used:**
☐Cigarettes	_____ per (☐day ☐week ☐month)	☐ 1st ☐ 2nd ☐3rd
☐Alcohol	_____ per (☐day ☐week ☐month)	☐ 1st ☐ 2nd ☐3rd
☐Other Drugs:_____	_____ per (☐day ☐week ☐month)	☐ 1st ☐ 2nd ☐3rd
☐None		

This child was born: ☐On time ☐Early ☐Late Length of pregnancy: _____ weeks

Type of labor: ☐Spontaneous ☐Induced Length of labor: _____ hours

Type of **delivery**: ☐Head first ☐Breech ☐C-section ☐Forceps/suction used
☐Cord around neck ☐Cord presented first ☐Hemorrhage ☐Infant injured during pregnancy
☐Other (describe) _____

Child's **birth weight**: _____ Length of stay in hospital for Mother: _____ days
for Child: _____ days

Check any of the following that **this child** had at birth or during the first week of life:

☐Difficulty breathing (If so, describe_____)

☐Supplemental oxygen (If so, how long?_____)

☐Seizures/convulsions ☐Feeding problems ☐Excess vomiting ☐Fever

☐Jaundice ☐Bilirubin lights used ☐Drugs/medications needed

☐Other complications (describe): _____

DEVELOPMENTAL HISTORY

Check all that applied to this child **when he/she was an infant or toddler**:

☐Overly active	☐Colicky	☐Hard to please	☐Cried more than other infants/toddlers
☐Frequently sick	☐Breathing problems	☐Frequent ear infections	☐Sleeping problems
☐Rocked self a lot	☐Head banging	☐Poor eye contact	☐Rigid about routines/rituals

☐Odd or unusual behaviors/interests ☐Did not smile when others smiled at him/her

☐Uninterested in other children ☐Uninterested in social games (e.g., peekaboo)

☐Other problems (describe here):_____

Give approximate ages when this child did the following:

Large Movements

Sat without support _____

Crawled/crept _____

Stood without help_____

Walked alone _____

Small Movements

Picked up small objects _____

Fed him/herself _____

Held a crayon _____

Language

Said "mama or dada" _____

Spoke first words _____

Talked in 2-3 word phrases _____

Talked in full sentences _____

Toileting

Bladder trained _____

Bowel trained _____

Did this child have any of these intervention services **between the ages of 0-3 years**?

Speech-language therapy? ☐No ☐Yes

Occupational therapy? ☐No ☐Yes

Physical therapy? ☐No ☐Yes

MEDICAL HISTORY

Please check if this child has had any of the following and write at what ages they occurred:

☐ Head injury/concussion age:_____
☐ Seizures/convulsions age:_____
☐ Meningitis or encephalitis age:_____
☐ Stroke age:_____
☐ Cancer age:_____
☐ Diabetes age:_____
☐ Asthma age:_____
☐ COVID-19 age:_____
☐ Allergies (please list: _____) age:_____

☐ Appetite/weight problems age:_____
☐ Sleep problems age:_____
☐ Vision problems age:_____
☐ Hearing problems age:_____
☐ Heart problems/hypertension age:_____
☐ Chronic Kidney Disease age:_____
☐ Headaches/migraines age:_____
☐ Poisoning age:_____

Please describe any other **serious illnesses, injuries, operations, or inpatient hospitalizations** that this child has had: age:

_____ _____

_____ _____

_____ _____

Medications this child is taking **currently**:

Name of medicine	Dose (How much):	Frequency (How often):	Prescribed by (Name of provider):
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who is this child's primary care **physician**? _____

Has this child had a recent **vision** exam? ☐No ☐Yes Does the child wear glasses/contacts? ☐No ☐Yes

Has this child had a recent **hearing** check? ☐No ☐Yes Does the child use hearing aids? ☐No ☐Yes

Has this child ever had a **neurological exam**? ☐No ☐Yes, with the following result:_____

_____

Has this child ever had an **EEG**? ☐No ☐Yes, with the following result_____

Has this child ever had an **MRI** or **CT**? ☐No ☐Yes, with the following result_____

PSYCHIATRIC HISTORY

Has this child ever received a **mental health diagnosis** from a medical provider (e.g., major depressive disorder, generalized anxiety disorder, adjustment disorder, ADHD, autism spectrum disorder)?

☐No ☐Yes If yes, list diagnoses:

_____

_____

Has this child ever received **other mental health treatment**, such as working with a psychiatrist for medication or going to the hospital for an emergency mental health issue?

☐No ☐Yes If yes, list name of provider(s), when this child was treated, and type of treatments:

_____

_____

Has this child ever received **counseling** (either individually or with the family)?

☐No ☐Yes If yes, list name of counselor(s), when this child was treated, and type of treatments:

_____

_____

Has **Children, Youth, and Families Department (CYFD)** or any other Child Protective Services (CPS) agency **ever been involved** with this child or others in the home? ☐No ☐Yes If yes, please explain:_____

_____

Has this child had any unusual, **traumatic** or possibly **stressful events** that you think may have had an impact on his/her development and current functioning ☐No ☐Yes ? If yes, please describe the event(s). Include the child's age at the time of the event(s). _____

SCHOOL HISTORY

Has this child received a **Child Find** evaluation? ☐No ☐Yes If yes, what were the results?: _____

_____

Did this child receive **intervention services** in preschool? ☐No ☐Yes If yes, please describe: _____

_____

What **school** is this child going to now?_____

What **grade** is this child in (e.g., preschool, kindergarten, 1st, 2nd, etc.)? _____

Total **number of schools** this child has attended: _____

Has this child ever **repeated** a grade? ☐No ☐Yes If yes, which grade(s)_____

Has this child **skipped** a grade in school? ☐No ☐Yes If yes, which grade(s) _____

Does or did this child have any trouble with **math**? ☐No ☐Yes If yes, explain: _____

_____

Does or did this child have any trouble with **reading**? ☐No ☐Yes If yes, explain:_____

_____

Does or did this child have any trouble with **spelling or writing**? ☐No ☐Yes If yes, explain:_____

_____

This child's classroom instruction is in: ☐English only ☐English with Spanish-speaking aide ☐Spanish only ☐Dual language (____% English, ____% Spanish)

This child reads and writes in ☐English only ☐Spanish only ☐English and Spanish ☐Other_____

Please circle if this child has ever had any of the following:

Individualized Education Program (IEP)	**Current**	**Past**	**Never**
504 Plan	**Current**	**Past**	**Never**
Behavioral Intervention Plan (BIP)	**Current**	**Past**	**Never**
Student Assistance Team (SAT) Intervention Plan	**Current**	**Past**	**Never**

If yes, what is (or what was) the main reason? Check below:

☐Specific Learning Disability	☐Intellectual Disability	☐Traumatic Brain Injury
☐Speech or Language Impairment	☐Autism	☐Emotional Disturbance
☐Other Health Impairment	☐Developmental Delay	☐Orthopedic Impairment
☐Gifted	☐Vision Impairment	☐Hearing Impairment
☐Multiple Disabilities		

Please circle if this child has ever received any of the following special education services **in school**:

Speech-language therapy	**Current**	**Past**	**Never**	Social Work/counseling	**Current**	**Past**	**Never**
Occupational therapy	**Current**	**Past**	**Never**	Physical therapy	**Current**	**Past**	**Never**
Other: _____	**Current**	**Past**	**Never**				

Does this child get special education services **right now**? ☐No ☐Yes If yes, in which of the following settings:

☐**Inclusion** setting services only (i.e., all special education provided in regular education classroom)

☐**Segregated** services primarily (i.e., most academic coursework provided in segregated/special education classroom)

☐**Mixed** settings (i.e., some classes in regular education classroom and in segregated/special education classroom)

If **Mixed**, Please list child's classes taught in **Inclusion** setting: _____

Please list child's classes taught in **Segregated** setting: _____

Please check below if this child ever received any of the following testing:

☐School/Psycho-educational Evaluation ☐Psychological Evaluation ☐Autism Evaluation

☐Neuropsychological Evaluation ☐Speech/Language Evaluation ☐Occupational Therapy Evaluation

☐Physical Therapy Evaluation

If this child has ever received any of these types of testing, please attach the records/report from the evaluation(s).