

HEALTH HISTORY

CHILD PATIENT

Name of Patient		Date	
Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth / / Age
Address			
Address		Phone Number	
Parent(s) Name			
Education Level Attained			Age
Parent(s) Name			
Education Level Attained			Age
Legal Guardian			
Person completing form			
Email			

FAMILY HISTORY

Family history can often be helpful in understanding a child's problems.

Please check any box that applies:

<i>Has anyone in the family had:</i>	<i>Siblings</i>	<i>Parents</i>	<i>Extended Family</i>
Motor problems			
Reading problems			
Speech/language problems			
School/learning problems			
Alcohol/drug problems			
Anxiety, depression, other psychological disorders			
Seizures/epilepsy			
Attention problems/hyperactivity			

Please list all family members (in or out of house) and other people currently in the house:

NAME	RELATIONSHIP	AGE	CURRENTLY IN HOUSE?

Parents are: Married Living together Divorced Separated Widowed

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BIRTH HISTORY

How would you describe your pregnancy? _____

Did you experience complications? If so, please list: Example, Gestational Diabetes, Pre-eclampsia, high blood pressure, etc? _____

Did you receive any vaccinations while pregnant? Yes No

Was any dental work done while pregnant? Yes No

If yes, what? _____

Did any stressful situations occur during pregnancy? Example, death in the family, loss of a spouse's job, separation, etc? _____

Please check what best describes your labor and birth of your child?

- | | | |
|---|--|--|
| <input type="checkbox"/> Normal (no interventions) | <input type="checkbox"/> Rh Factor problems | <input type="checkbox"/> Caesarian section |
| <input type="checkbox"/> Mother was sick | <input type="checkbox"/> Long/difficult labor | <input type="checkbox"/> Forceps or suction used |
| <input type="checkbox"/> Complications during birth | <input type="checkbox"/> Epidural given | <input type="checkbox"/> Induced |
| <input type="checkbox"/> Problems with the umbilical cord | <input type="checkbox"/> Facial/breech/brow presentation | |

Did your child have any of the following problems at birth?

- | | | |
|---|--|---|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Health problems | <input type="checkbox"/> Infection |
| <input type="checkbox"/> Low birth weight | <input type="checkbox"/> Problems with bones/joints | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Fever or seizures | <input type="checkbox"/> Required blood transfusions | <input type="checkbox"/> Intensive care |
| <input type="checkbox"/> Bruised anywhere | <input type="checkbox"/> Nerve problems | |

Does this/did this child have any birth defects? Yes No

If yes, what? _____

Describe what your child's temperament was like as an infant.

- | | | | |
|------------------------------------|---------------------------------|--|--|
| <input type="checkbox"/> Difficult | <input type="checkbox"/> Calm | <input type="checkbox"/> Sleepy | <input type="checkbox"/> Hyper sensitive |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Active | <input type="checkbox"/> Easily scared | <input type="checkbox"/> Frequent crying |
| <input type="checkbox"/> Sociable | <input type="checkbox"/> Cranky | <input type="checkbox"/> Happy | <input type="checkbox"/> Alert |

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Beside each subject, indicate whether it is an academic Strength or Weakness of your child:

English	S__	W__	Math	S__	W__	Music	S__	W__
History	S__	W__	Science	S__	W__	Creative Writing	S__	W__
Gym/Sports	S__	W__	Other languages	S__	W__	Other:	S__	W__
Art	S__	W__						

Beside each domain, indicate whether it seems a Strength or a Weakness in your child:

Vocabulary and Expression	S__	W__	Reading quickly	S__	W__
Creative Writing	S__	W__	Memorizing	S__	W__
Getting assignments done on time	S__	W__	Spelling	S__	W__
Understanding concepts	S__	W__	Planning	S__	W__
Reading comprehension	S__	W__	Concentration	S__	W__
“Good” behavior	S__	W__	Handwriting	S__	W__
Test Preparation	S__	W__	Organization	S__	W__

Is getting homework done a struggle? Yes No

BEHAVIOR/MENTAL HEALTH

Describe any sports or activities the child is involved in: _____

Indicate how many hours a week of “screen time” the child uses:

Computer	_____	Smart Device (phone, iPad, etc.)	_____
Computer games (DS, etc.)	_____	Television	_____

Describe the child’s family relationships; with parents and siblings: _____

Does your child have many friends? Yes No

Does the child appear to excel at or struggle to build relationships with their peers?

Excel Struggle Neither

If they struggle, why do you think that is? _____

What problems does the child have with peers, if any?

<input type="checkbox"/> None	<input type="checkbox"/> Bragging to peers	<input type="checkbox"/> Being teased
<input type="checkbox"/> Being physically attacked	<input type="checkbox"/> Rejected by peers	<input type="checkbox"/> Overly physically affectionate
<input type="checkbox"/> Being bullied	<input type="checkbox"/> Jealous of peers	

Does this child have self-esteem issues? Yes No

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During the first twelve months, was this child:

Difficult to get to sleep Yes No Irritable Yes No
 Difficult to be put on a schedule Yes No Alert Yes No
 Easy to comfort Yes No Affectionate Yes No
 Overactive/in constant motion Yes No Sociable Yes No
 Was the child breast fed? Yes No For how long? _____
 When was solid food introduced? _____
 Was there any evidence of food intolerances? Yes No
 If so, to what? _____

DEVELOPMENTAL HISTORY

How old was the child when (s)he:

	Average Age	Approximate Age	If not sure, please estimate		
Sat	4-7 mos		Early	Average	Late
Walked	12-17 mos		Early	Average	Late
Toilet Trained	18-36 mos		Early	Average	Late
Said first words	12-17 mos		Early	Average	Late
Began using sentences	36-60 mos		Early	Average	Late

SPEECH AND LANGUAGE

Has his/her hearing ever been tested? Yes No
 Does this child have a history of frequent ear infections? Yes No
 Has (s)he ever had tubes placed in her/his ears? Yes No
 Last hearing/audiology evaluation: PLACE _____ DATE: _____

Does this child have:

Any speech problems/difficulty speaking? Yes No
 Have any trouble understanding what is being said to him/her? Yes No
 Has (s)he ever had a Speech and Language Evaluation? Yes No
 If yes, where? _____ When? _____

RESULTS _____

Has (s)he ever had Speech/Language Therapy? Yes No
 Is (s)he currently receiving Speech/Language Therapy? Yes No
 If yes, where? _____
 Frequency: _____

MOTOR SKILLS

Does this child have fine motor problems (writing, drawing)? Yes No

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Which of the following has the child experienced in the last 12 months?

- | | | |
|---|---|--|
| <input type="checkbox"/> Serious illness/injury in immediate family | <input type="checkbox"/> Change of school | <input type="checkbox"/> Mother pregnant |
| <input type="checkbox"/> Parents separation/divorce | <input type="checkbox"/> Move to a new home | <input type="checkbox"/> Parent losing a job |
| <input type="checkbox"/> Birth of a sibling | <input type="checkbox"/> Death of immediate family member | |
| <input type="checkbox"/> None | <input type="checkbox"/> Other: _____ | |

Do you feel that this child exhibits any of the following symptoms more often than is typical for a child of his/her age?
(Please check any that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Often touchy/easily annoyed | <input type="checkbox"/> Often bullies/threatens | <input type="checkbox"/> Often irritable |
| <input type="checkbox"/> Often defies adult rules | <input type="checkbox"/> Initiates physical fights | <input type="checkbox"/> Changes in appetite |
| <input type="checkbox"/> Often angry/resentful | <input type="checkbox"/> Ever been arrested | <input type="checkbox"/> Diminished interest |
| <input type="checkbox"/> Often argues with adults | <input type="checkbox"/> Physically cruel to others | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Often loses temper | <input type="checkbox"/> Physically cruel to animals | <input type="checkbox"/> Restlessness or slowed down |
| <input type="checkbox"/> Blames others for mistakes | <input type="checkbox"/> Motor or vocal tics | <input type="checkbox"/> Fatigues, low energy |
| <input type="checkbox"/> Deliberately annoys | <input type="checkbox"/> Destroys property | <input type="checkbox"/> Feels worthless |
| <input type="checkbox"/> Often spiteful/vindictive | <input type="checkbox"/> Deliberately sets fires | <input type="checkbox"/> Becomes tearful easily |
| <input type="checkbox"/> Refuses to go to school | <input type="checkbox"/> Lies often | <input type="checkbox"/> Often sad |
| <input type="checkbox"/> Repeated nightmares | <input type="checkbox"/> Steals | <input type="checkbox"/> Indecisive/can't think |
| <input type="checkbox"/> Unusual fears | <input type="checkbox"/> Has run away | <input type="checkbox"/> Thinks about death |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Extreme mood swings | <input type="checkbox"/> Talks about suicide |
| <input type="checkbox"/> Self-conscious/clings | <input type="checkbox"/> Does not show emotions | <input type="checkbox"/> Hurts self |
| <input type="checkbox"/> Excessive need for reassurance | <input type="checkbox"/> Overreacts to touch/noise | <input type="checkbox"/> Currently uses drugs |
| <input type="checkbox"/> Self-injurious behavior | <input type="checkbox"/> Strange to bizarre ideas | <input type="checkbox"/> Currently drinks beer or alcohol |
| <input type="checkbox"/> Worry of future events | <input type="checkbox"/> Used drugs in the past | <input type="checkbox"/> Used beer or alcohol in the past |
| <input type="checkbox"/> Repeats certain actions | <input type="checkbox"/> Poor social interactions | <input type="checkbox"/> Can't stop thinking about things |
| <input type="checkbox"/> Somatic complaints
(headache/stomach) | <input type="checkbox"/> Gets upset by changes in
routine | <input type="checkbox"/> Excessive preoccupation with
objects or ideas |
| <input type="checkbox"/> Difficulty maintaining friendships | | |

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Please place a check mark in the column which <u>best</u> describes the child:	Not at all	Just a little	Pretty much	Very much
Often fails to give close attention to details or makes careless mistakes in schoolwork or other activities				
Often has difficulty sustaining attention in tasks or play activities				
Often does not seem to listen when spoken to directly				
Often does not follow through on special instructions and fails to finish schoolwork, or chores (not due to oppositional behavioral failure to understand directions)				
Often has difficulty organizing tasks and activities				
Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)				
Often loses things necessary for tasks or activities (toys, school assignments, pencils or books)				
Is often easily distracted by extraneous stimuli				
Is often forgetful in daily activities				
Often fidgets with hands or feet or squirms in seat				
Often leaves seat in classroom or in other situation in which remaining seated is expected				
Often runs about or climbs excessively in situation where it is inappropriate (in adolescents, may be limited to subjective feelings or restlessness)				
Often has difficulty playing or engaging in leisure activities quietly				
Is often "on the go" or often acts as if "driven by a motor"				
Often talks excessively				
Often blurts out answers before questions have been completed				
Often has difficulty waiting turn				
Often interrupts or intrudes on others (butts into conversation or games)				

