Child and Family History

Child Name:		Date of Birth	Age
Biological Mother's Name		Age	Education:
Biological Father's Name		Age	Education:
School Information		Grade Level	
Teacher's Name:			
Has the child repeated a grade? Yes No		Is this child in any special services? Yes No	
If so, which grade?		If so, what type?	

DEVELOPMENTAL AND MEDICAL HISTORY

Pregnancy and Delivery

Length of pregnancy (e.g., full term, 32 weeks, etc.)		Mother's age when child was born	
Length of delivery (number of hours from initial labor pains to birth)		Child's weight	

Did any of the following conditions occur during pregnancy/delivery?

1) Bleeding	Yes	No
2) Excessive weight gain (more than 30 lbs)	Yes	No
3) Toxemia/Preeclampsia	Yes	No
4) Rh Factor incompatibility	Yes	No
5) Frequent nausea or vomiting	Yes	No
6) Serious illness or injury	Yes	No
7) Took prescription medications If yes, Name of medications: _____	Yes	No
8) Took illegal drugs	Yes	No
9) Used alcoholic beverage If yes, approximate number drinks per week? _____	Yes	No
10) Smoked cigarettes If yes, approximate number of cigarettes per day? _____	Yes	No
11) Delivery was induced	Yes	No
12) Forceps were used during delivery	Yes	No
13) Had a breech delivery	Yes	No
14) Had a cesarean section delivery	Yes	No
15) Other problems-Please describe _____	Yes	No

Did any of the Following conditions affect your child during deliver or within the first few days after birth?

1) Injured during delivery	Yes	No
2) Cardiopulmonary distress during delivery	Yes	No
3) Delivered with cord around neck	Yes	No
4) Had trouble breathing following delivery	Yes	No
5) Needed Oxygen	Yes	No
6) Was cyanotic, turned blue	Yes	No
7) Was jaundiced, turned yellow	Yes	No
8) Had an infection	Yes	No
9) Had seizures	Yes	No
10) Was given medications	Yes	No
11) Was in hospital more than 7 days Why? _____	Yes	No

Turn Over ➡

Infant Health and Temperament

During the first 12 months, was your child:

1) Difficult to feed	Yes	No
2) Difficult to get to sleep	Yes	No
3) Colicky	Yes	No
4) Difficult to put on a schedule	Yes	No
5) Sociable	Yes	No
6) Easy to comfort	Yes	No
7) Overactive, in constant motion	Yes	No
8) Very stubborn, challenging	Yes	No

Early Development Milestones

At what age did your child first accomplish the following:

1) Sitting without help	Early	Normal	Late
2) Crawling	Early	Normal	Late
3) Walking alone, without assistance	Early	Normal	Late
4) Using single words (e.g. mama, dada, ball, etc)	Early	Normal	Late
5) Putting two or more words together (e.g. mama up)	Early	Normal	Late
6) Bowel training, day or night	Early	Normal	Late
7) Bladder training, day or night	Early	Normal	Late

Health History

Doctor's Name:			
Phone Number:		Date of Last Physical Exam:	
Has this child ever had a neurological exam? Yes No	If Yes	Doctor's Name	
Date of Exam:		Reason for Exam:	

At any time has your child had the following:

1) Asthma	Never	Past	Present
2) Allergies	Never	Past	Present
3) Diabetes, arthritis, or other chronic illnesses	Never	Past	Present
4) Epilepsy or seizure disorder	Never	Past	Present
5) High Fevers (over 103)	Never	Past	Present
6) Febrile seizures (seizures due to fever)	Never	Past	Present
7) Chicken pox or other common childhood illnesses	Never	Past	Present
8) Heart or blood pressure problems	Never	Past	Present
9) Broken bones	Never	Past	Present
10) Several cuts requiring stitches	Never	Past	Present
11) Head injury with loss of consciousness	Never	Past	Present
12) Lead Poisoning	Never	Past	Present
13) Speech or language problems	Never	Past	Present
14) Chronic ear infections	Never	Past	Present

At any time has your child had the following:				continued
15) Hearing difficulties	Never	Past	Present	
16) Eye or vision problems	Never	Past	Present	
17) Fine motor/handwriting problems	Never	Past	Present	
18) Gross motor difficulties, clumsiness	Never	Past	Present	
19) Appetite problems (over eating or under eating)	Never	Past	Present	
20) Sleep Problems (falling asleep, staying asleep)	Never	Past	Present	
21) Soiling problems	Never	Past	Present	
22) Wetting problems	Never	Past	Present	
23) Other health difficulties (please describe)	Never	Past	Present	

Hospitalizations/Surgeries Including dates ,complications, adverse reactions to anesthesia, outcomes, etc.	

Current Medication:				
Medication Name	Prescribed Dosages	Dates of Prescription	Refills	Prescribing Doctor

Allergies (adverse reactions to medication/food/etc)	

Past Psychiatric History (Mental Health and Chemical Dependency)

Has this child ever had Psychological or psychiatric exam? Yes No	If Yes	Date of Exam	
Doctor's Name		Reason for Exam:	
Hospitalizations			
Prior Outpatient Therapy			
Previous Practitioners and Dates of Treatment	Name	Dates	
	Name	Dates	
Previous Treatment Interventions			
Response to Treatment interventions including medications			

Turn Over ⟶

Family Health History	
Have any family member had any of the following? BOTH MOM AND DAD'S FAMILY – (Blood Kin)	
If you check the box, please specify family member's relationship to this child. If child is not living with biological parents, please indicate health information on ***biological parents*** *if known.*	
	Name and Relationship of Family Member to the Patient
☐ Depression	
☐ Suicide	
☐ Alcohol/Drugs	
☐ Emotional Disturbance	
☐ Mental Illness	
☐ Mental Retardation	
☐ Nervousness/worry	
☐ Seizures or Epilepsy	
☐ Reading Problems	
☐ Other Learning Problems	
☐ Speech or Language Problems	
☐ "Nervous Breakdown"	
☐ Tic or Tourette's Disorder	
☐ ADHD or ADD	
☐ Any Blood Kin been arrested?	
☐ Other problems, disorders, or disabilities?	
Please explain:	

Signature of Person Completing this Form

Relationship to Patient