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CHILD HISTORY FORM

Today's Date: ____________________

Completed By (Name/Relation): ____

I. GENERAL INFORMATION:

Child's Name (include nickname, if any): ____

Child's Address: ____

Date of Birth: ______________________ Home/cell phone: ______________________

Father's Name: ______________________ Mother's Name: ______________________

School Attended: ______________________ School District: ______________________

Pediatrician: ________________________ Telephone: ________________________

Address: ____

II. PRESENTING PROBLEM(S):

____

____

____

____

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III. BIRTH AND INFANT DEVELOPMENT:

1. Was this child adopted? ___ Yes ___ No

2. Were there any complications during this pregnancy (e.g., edema, toxemia, emotional stress, high blood pressure, infections, alcohol/drug use, accidents/injuries)? Yes No

   If **YES**, indicate child's gestational age and details: ____________________

   ____

3. Were there any complications during or shortly after birth (e.g., pre-term, breathing issues, low birth weight, jaundice, infection, poor feeding, NICU)? Yes No

   If **YES**, indicate complications and the outcomes: ____________________

   ____

4. Developmental Deficits:

a.	Difficulty sucking as an infant?	[ ] Yes	[ ] No
b.	Difficulty chewing as an infant?	[ ] Yes	[ ] No
c.	Difficulty swallowing as an infant?	[ ] Yes	[ ] No
d.	Sleeping problems as an infant?	[ ] Yes	[ ] No
	Describe them: ____________________		
e.	Was the baby normally active?	[Yes	[ ] No
f.	Was the baby limp?	[Yes	[ ] No
g.	Was the baby stiff?	[ ] Yes	[ ] No
h.	Did the baby show unusual trembling?	[ ] Yes	[ ] No
i.	Did the baby fail to grow normally?	[Yes	[ ] No
j.	Did the baby fail to gain weight?	[Yes	[ ] No

5. At what age did your child:

   a. Crawl: ____________________

   b. Sit without assistance: ____________________

   c. Stand without assistance: ____________________

d. Walk without assistance: ______________________________

e. Say meaningful words: ______________________________

f. Toilet training:

i. Urine: ______________________________

ii. Bowel: ______________________________

iii. Bed wetting? ______________________________

iv. Other: ______________________________

____

IV. SPEECH, LANGUAGE AND HEARING:

1. Was your child very quiet as a baby (i.e., did not babble and coo as much as most babies)?
   [ ] Yes [ ] No
2. Did you ever think your child had a hearing issue? [ ] Yes [ ] No

   If **YES**, why? ______________________________
3. Does your child respond consistently to sounds and speech? [ ] Yes [ ] No
4. How much does your child talk now? [ ] no speech (mute) [ ] minimal [ ] average
5. How much of your child's speech can you understand? [ ] all [ ] most
   [some [ ] little
6. How does your child make his/her needs known to others?

   [ ] gestures [ ] single words [ ] sentences

   Other: ______________________________
7. Does your child seem to speak as well as others of the same age? [Yes [No
8. Does your child seem to hear and respond as well as others of the same age? [Yes] No
9. Does your child understand speech as well as others of the same age? [ ] Yes [ ] No
10. Can your child follow simple directions? Yes] No
11. Can your child follow a series of directions? [Yes [No

12. Does your child's voice sound like other children's voices? [ ] Yes] No

If **NO**, describe (you may check more than one):

] very loud [ ] hoarse [ ] high or low pitch for age and sex

] nasaly [ ] congested

13. Does your child have issues with any of the following? (check all that apply)

[ ] pronouncing words (note specific sounds if possible): ____________

[ ] small vocabulary

[ ] stuttering or stammering (describe): ____________

V. EDUCATIONAL HISTORY:

1. What grade is your child in? ____________
2. Class placement? [ ] regular classroom] ESL] bilingual special class
3. What is his/her best subject? ____________
4. What is his/her worst subject? ____________
5. What are his/her average grades in:

English: ______ Math: ______ Reading: ______

Writing: ______ Science: ______ Social Studies: ______

History: ______

6. Has your child ever repeated a grade? [ ] Yes [ ] No

If **YES**, what grade and for what reason? ____________

7. History of suspensions/expulsions?] Yes] No

If **YES**, please give details (e.g., grade, what for): ____________

____

8. Has your child ever received special education services (e.g., IEP)? [ ] Yes [ ] No

If **YES**, please give details (e.g., grade, what for, and any accommodations received):

____

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VI. MEDICAL HISTORY:

1. List previous evaluation(s) (e.g., audiological, medical, psychological/neuropsychological, educational, neurological, ENT, EEG, etc.):

Name of Person Who Saw Child	When Evaluation Was Done	Why Evaluation Was Performed	Results/ Recommendations

2. Does your child currently take any medicine on a regular basis? If so, give name of medicine, dosage, how often it is given, and the reason he or she takes it.

____

____

____

3. What major childhood illnesses has your child had (e.g., mumps, measles, chicken pox, asthma, etc.)?

____

____

4. Does (did) your child suffer from frequent colds? [ ] Yes [No
5. Does (did) your child suffer from frequent ear infections? [ ] Yes [ ] No
6. Please list surgical history and age (e.g., ear tubes, tonsillectomy, other)?

____

____

7. Has your child ever had an injury to the head or spine? [ ] Yes [No

   If **YES**, give date and explain: ____________________________________

8. Has your child ever had high fevers? [ ] Yes [ ] No

If **YES**, please indicate the degree and describe:______________________________

____

9. Has your child ever had convulsions (seizures)? [ ] Yes [ ] No

If **YES**, please describe type of convulsion, when it occurred, and how long it lasted:

____

____

10. Has your child ever had fainting spells? [ ] Yes [ ] No

11. Does your child have any allergies? [ ] Yes [ ] No

If **YES**, describe: ____

____

12. Does your child have vision problems? [Yes [ ] No

13. Does your child have hearing problems? [Yes] No

14. Has your child been hospitalized? [ ] Yes [No

If **YES**, please describe (reason, dates, place, outcomes, child's reaction): __________

____

____

15. Has your child ever received speech/language therapy, occupational therapy, or physical therapy? Yes] No

If **YES**, please describe when/where/who: _____________________________

____

____

16. Has your child ever lost consciousness or been knocked out? [ ] Yes [ ] No

If **YES**, please describe: ____

VII. DESCRIPTION OF CHILD:

1. Please describe your child's personality: ________________________________

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2. Does your child separate easily? [ ] Yes [ ] No
   If **NO**, please describe: ______________________________

3. How does your child interact with other children (siblings and peers)? __________

4. Does your child prefer to play alone?] Yes [ ] No

5. How does your child interact with adults (parents and others)? __________

   ____

6. What are your child's favorite activities and toys? __________

   ____

7. Describe TV habits (e.g., favorite shows, hours of TV watched per day, etc.)? __________

   ____

8. How is your child's self-care (initiative and capability)? __________

   ____

9. What are your child's sleeping habits (hours of sleep, napping, nightmares)? __________

   ____

10. What are your child's eating habits (e.g., picky, etc.)? __________

    ____

11. What habits does your child have (head banging, thumb sucking, nail biting, tics or twitches, toe walking, staring into space)?

    ____

12. Describe your child's typical mood:

    ____

VIII. PSYCHOSOCIAL HISTORY:

1. Who lives in the home? ______________________________

   ____

2. What language is spoken in the home? __________

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3. Please describe the home: ____________________

4. Are parents: [ ] married [ ] separated [ ] divorced

   If separated/divorced, how old was your child when this occurred? ____________

5. Is either parent deceased? [ ] Yes [ ] No

6. Was either parent married previously? [Yes] No

   If **YES**, which parent: ____________________

7. Are there significant conflicts between parent and child? [ ] Yes [No

8. Who disciplines and how? ____________________

   ____

9. How does child respond to discipline? ____________________

10. Does your child relate well to others? [ ] Yes [ ] No

11. Does your child have a best friend? [ ] Yes [ ] No

12. Has your child had any opportunities for peer group experiences through organized activities? [ ] Yes [ ] No

13. Have there been any incidents in the child's life that you believe caused noticeable changes in his or her behavior? [ ] Yes [ ] No

    If **YES**, describe: ____________________

    ____

14. Has your child had emotional adjustment issues or behavioral problems? [ ] Yes [ ] No

    If **YES**, explain: ____________________

    ____

    ____

15. Has your child ever been under the care of a psychologist or psychiatrist? [ ] Yes [ ] No

    If **YES**, by whom, when, & for what issue(s)? ____________________

    ____

    ____

If **YES**, please list address and phone number of the psychologist/psychiatrist:

____

____

If **YES**, was (or is) the psychological treatment helpful? [ ] Yes [ ] No

IX. FAMILY HISTORY:

1. Parents:

	Age	Education (grade)	Occupation	Health
Mother:	______	____________	______________	_____________
Father:	______	____________	______________	_____________

2. Siblings (list names of children in order of birth):

Name	Age	Education (grade)	Health	Behavior Problem?
____________	______	____________	____________	______________
____________	______	____________	____________	______________
____________	______	____________	____________	______________
____________	______	____________	____________	______________
____________	______	____________	____________	______________

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3. Did anyone in your immediate family or other relative have any of the following? If so, who?

	No	Yes	Who
Neurological disease	[ ]	[ ]	________
Seizures (epilepsy)	[ ]	[ ]	________
Hearing problems	[ ]	[ ]	________
Visual problems	[ ]	[ ]	________
Color weakness or blindness	[ ]	[ ]	________
Emotional/psychiatric problems	[ ]	[ ]	________
Intellectual disability	[ ]	[ ]	________
Hyperactivity	[ ]	[ ]	________
Learning problems	[ ]	[ ]	________
Left-handedness	[ ]	[ ]	________
Substance use/abuse	[ ]	[ ]	________

4. Does any disease run in the family? [ ] Yes [ ] No

Describe: ____

____

____

____

5. Give any other pertinent information that you feel would be helpful to us in the evaluation of your child. ____

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____