CHILDHOOD HISTORY FORM

Child's Name:_____ DOB:_____ Age:_____ Sex:_____

Address:_____ Phone #:_____

City/State/Zip:_____ Alt. Phone #:_____

Child's School:_____
School Name School Address

Grade:_____ Special Placement (if any):_____

Child is presently living with:

☐ Natural Mother ☐ Natural Father ☐ Stepmother ☐ Stepfather
☐ Adoptive Mother ☐ Adoptive Father ☐ Foster Mother ☐ Foster Father
☐ Grandparent ☐ Other (Specify):_____

Non-residential adults involved with this child on a regular basis:

_____

_____

Source of Referral: Name:_____ Phone:_____

Address:_____ City/State/Zip:_____

Briefly state main problem this child is having:_____

_____

_____

PARENTS

Biological Mother:_____ Age:_____ Age at time of pregnancy with patient:_____

Occupation:_____

School: Highest grade completed:_____

Learning problems:_____

Attention problems:_____

Behavior problems:_____

Medical Problems:_____

Have any of your blood relatives experienced problems similar to those your child is experiencing? If so, describe:

_____

_____

Biological Father:_____ Age:_____

Occupation:_____ Age at time of child's birth:_____

School: Highest grade completed:_____

Learning problems:_____

Attention problems:_____

Behavior problems:_____

Medical Problems:_____

Have any of your blood relatives experienced problems similar to those your child is experiencing? If so, describe:

_____

_____

Client Name:_____

Name Age Medical, Social or School Problems

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

PREGNANCY – Complications

- ☐ Duration of pregnancy (weeks):_____
- ☐ Excessive vomiting; hospitalization required?
- ☐ Excessive blood loss
- ☐ Threatened miscarriage
- ☐ Toxemia
- ☐ X-ray studies during pregnancy
- ☐ Smoked during pregnancy; If yes, # per day: _____
- ☐ Alcohol consumption during pregnancy; Describe consumption:_____
- ☐ Operation(s) (specify):_____ _____
- ☐ Infection(s)(specify):_____ _____
- ☐ Other illness (specify):_____ _____
- ☐ Medications taken during pregnancy (specify):_____ _____

DELIVERY

Type of Labor: ☐ Spontaneous ☐ Induced Duration (hrs):_____
Type of Delivery: ☐ Normal ☐ Breech ☐ Caesarean
Complications: ☐ Cord around neck ☐ Hemorrhage ☐ Infant injured during delivery
☐ Other:_____ Birth Weight:_____

POST DELIVERY PERIOD

☐ Jaundice ☐ Cyanosis (turned blue) ☐ Incubator Care
☐ Infection (specify):_____ # of days infant was hospitalized after delivery:_____

INFANCY PERIOD

Were any of the following present (to a significant degree) during the first few years of life? If so, describe:

- ☐ Did not enjoy cuddling:_____
- ☐ Not calmed by being held or stroked:_____
- ☐ Difficult to comfort:_____
- ☐ Colic:_____
- ☐ Excessive restlessness:_____
- ☐ Diminished sleep:_____
- ☐ Frequent head banging:_____
- ☐ Difficult nursing:_____

TEMPERAMENT

Rate the following behaviors as your child appeared **during infancy and toddlerhood**:	Good	Average	Poor
Activity Level: How active has your child been from an early age	☐	☐	☐
Distractibility: How well did you child pay attention	☐	☐	☐
Adaptability: How well did your child deal with transition and change	☐	☐	☐
Approach/Withdrawal: How well did your child respond to new things (i.e. places, people, food, etc.)	☐	☐	☐
Intensity: Whether happy or unhappy, how aware are others of your child's feelings	☐	☐	☐
Mood: What was your child's basic mood	☐	☐	☐
Regularity: How predictable was your child in patterns of sleep, appetite, etc.	☐	☐	☐

Client Name:_____

MEDICAL HISTORY

If your child's medical history includes any of the following, note age when incident or illness occurred and any other pertinent information:

- ☐ Operations: _____
- ☐ Nightmares, night terrors, sleep walking, sleep talking
- ☐ Is a very restless sleeper
- ☐ Hospitalization for illness:_____
- ☐ Convulsions: ☐ With fever ☐ Without fever
- ☐ Eye problems:_____
- ☐ Persistent high fevers:_____
- ☐ Allergies or Asthma:_____
- ☐ Issues with Appetite:_____
- ☐ Child easily settles down to sleep
- ☐ Sleep through the night without disruption
- ☐ Snores
- ☐ Head injuries:_____
- ☐ Coma:_____
- ☐ Tics (repetitive, non-purposeful movements):
- ☐ Ear problems:_____
- ☐ Poisoning:_

DEVELOPMENT MILESTONES

If you can recall, record the age at which your child reached the following developmental milestones:

	Age	Early	Normal	Late	Don't Recall
Smiled		☐	☐	☐	☐
Sat without support		☐	☐	☐	☐
Crawled		☐	☐	☐	☐
Walked without assistance		☐	☐	☐	☐
Spoke first words		☐	☐	☐	☐
Said phrases		☐	☐	☐	☐
Bladder trained (day)		☐	☐	☐	☐
Bladder trained (night)		☐	☐	☐	☐
Bowel trained (day)		☐	☐	☐	☐
Bowel trained (night)		☐	☐	☐	☐
Named colors		☐	☐	☐	☐
Tied shoelaces		☐	☐	☐	☐
Said alphabet in order		☐	☐	☐	☐
Began to read		☐	☐	☐	☐

COORDINATION

Excessive number of accidents compared to other children: yes/no

Rate your child on the following skills:

	Good	Average	Poor
Walking	☐	☐	☐
Running	☐	☐	☐
Throwing	☐	☐	☐
Catching	☐	☐	☐

	Good	Average	Poor
Shoelace tying	☐	☐	☐
Buttoning	☐	☐	☐
Writing	☐	☐	☐
Athletic abilities	☐	☐	☐

Client Name:_____

PRESENT MEDICAL STATUS

Height:_____ Weight:_____

Present physical illness for which the child is being treated:_____

Medications child is taking on ongoing basis:_____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his or her age? If not, why not?_____

Child's overall level of intelligence compared to other children? ☐ Above ☐ Average ☐ Below

SCHOOL HISTORY

Rate your child's school experiences related to **academic learning**:

	Good	Average	Poor
Nursery School	☐	☐	☐
Kindergarten	☐	☐	☐
Current Grade	☐	☐	☐

To the best of your knowledge, at what grade level is your child functioning:

Reading:_____ Spelling:_____ Arithmetic:_____

Has your child ever had to repeat a grade? If so, when?_____

Kinds of special counseling or remedial work your child is currently receiving:_____

Describe briefly any academic school problems:_____

_____

Rate your child's school experiences related to **behavior**:

	Good	Average	Poor
Nursery School	☐	☐	☐
Kindergarten	☐	☐	☐
Current Grade	☐	☐	☐

Does your child's teacher describe any of the following as significant problems?

- ☐ Doesn't sit still in his/her seat
- ☐ Frequently gets up and walks around class room
- ☐ Shouts out. Does not wait to be called on
- ☐ Won't wait his/her turn
- ☐ Doesn't cooperate well in group activities
- ☐ Typically does better in a one-to-one relationship
- ☐ Doesn't respect the rights of others
- ☐ Doesn't pay attention during storytelling or show and tell

Describe briefly any other behavioral problems:_____

_____

Client Name:_____

PEER RELATIONSHIPS

Does your child seek friendships with peers? ☐ Yes ☐ No

Is your child sought by peers for friendship? ☐ Yes ☐ No

Does your child play with children primarily his or her own age? ☐ Younger ☐ Older ☐ Same Age

Describe briefly any problems your child may have with peers:_____

_____

HOME BEHAVIOR

All children exhibit, to some degree, the behaviors listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her own age.

- ☐ Fidgets with hand, feet or squirms in seat
- ☐ Easily distracted by extraneous stimulation
- ☐ Has difficulty playing quietly
- ☐ Boundless energy and poor judgment
- ☐ Impulsivity (poor self-control)
- ☐ History of temper tantrums
- ☐ Temper outbursts
- ☐ Frustrates easily
- ☐ Sloppy table manners
- ☐ Often talks excessively
- ☐ Poor memory
- ☐ A "different" child
- ☐ Excessive number of accidents
- ☐ Acts like he/she is driven by a motor
- ☐ Doesn't seem to learn from experience
- ☐ Does not appear to listen to what's being said
- ☐ Has problems following through with instructions (usually not due to opposition or, failure to comprehend)
- ☐ Interrupts or intrudes on others (often not purposeful or planned but impulsive)
- ☐ Has difficulty awaiting his turn in games or group situations
- ☐ Blurts out answers to questions before they have been completed
- ☐ Has difficulty paying attention during tasks or play activities
- ☐ Loses things necessary for tasks or activities at home
- ☐ Sudden outbursts of physical abuse of other children
- ☐ Wears out shoes more frequently than siblings
- ☐ Has difficulty remaining seated when required to do so
- ☐ Shifts from one uncompleted activity to another

Does your child create more problems, either purposeful or non-purposeful, within the home setting than his or her siblings?_____

Does your child have difficulty learning from his/her experiences? ☐ Yes ☐ No

Types of discipline you use with your child:_____

_____

Is there a particular form of discipline that has proven effective?_____

Have you participated in a parenting class or obtained other forms of information concerning discipline and behavior management? ☐ Yes ☐ No

INTEREST AND ACCOMPLISHMENTS

What are your child's main hobbies and interests?_____

What are your child's areas of greatest accomplishment?_____

What does your child enjoy doing the most?_____

What does your child dislike doing the most?_____

What do you like about your child?_____

LIST NAMES AND ADDRESSES OF ANY OTHER PROFESSIONALS CONSULTED (Including family doctor):

1._____

2._____

3._____

4._____

Client Name:_____

ADDITIONAL REMARKS:

Please write any additional remarks you may wish to make regarding your child: