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CHILDHOOD HISTORY FORM

Thank you for your patience and hard work in filling out this form. It will help me in my work with you and your child.

Child's Name: _____
Birth Date: ____/_____/_____ Age_____ Gender:_____
Person completing this form: _____ Phone:_____
Child's School:_____ Grade:_____
Special Placement (if any): _____

How many people live in the household?_____
Child is presently living with:
____Natural Mother ____Natural Father ____Stepmother ___Stepfather
____Adoptive Mother ____Adoptive Father ____Foster Mom ___Foster Dad
____Other (specify)_____

Briefly state main problem of your child: _____

Is your child adopted? _____ If so, briefly describe the circumstances of the adoption:
_____

If adopted, do you have the background history on the child?_____

PREGNANCY:
Was this pregnancy planned? _____
During this pregnancy was the mother under a doctor's care? _____

Check any that apply for this pregnancy:	Please Describe
____Anemia	_____
____Elevated Blood Pressure	_____
____Toxemia	_____
____Bleeding	_____
____Excessive Nausea/Vomiting	_____
____Injury	_____
____Infections	_____
____Operations	_____
____Hospitalizations	_____
____X-rays	_____
____Medications Taken (list)	_____
____Emotional Problems	_____
____Threatened Miscarriage	_____
____Premature Labor	_____
____Severe Emotional Distress	_____
____Other _____	_____

PREGNANCY CONTINUED:

(Please complete the following questions regarding this pregnancy with **Y** for yes and **N** for no)

Smoking during pregnancy?____ Number of cigarettes per day?_____
Amount of alcohol consumed during pregnancy? _____
Other drugs used during pregnancy? _____

BIRTH HISTORY:

Mother's age at time of birth? ____years
Father's age at time of birth? ____years
Was your child premature? ___ # of weeks ____
Was your child born late? _____ # of weeks ____
Was labor induced? _____Was induced labor planned?____
Was the mother under anesthesia during childbirth?____
If yes: ____Local ____Spinal ____General
Was this a breech (feet first) delivery? ____
Were forceps or suction used? ____
Was the delivery unusual in any way? ____ How? _____

Was your baby born cesarean? ____ If yes, please describe any complications_____

Did your baby have: Any injuries during delivery? _____
Breathing problems? _____
Problems with infection _____
Me conium (baby's stool) present? _____
Was your baby normally active? _____
Birth Weight? _____ Apgar Scores (if known)_____
Were any birth defects evident?____ If so, please describe _____

Number of days your baby was in the hospital after delivery? _____
Please add any comments regarding the pregnancy or delivery:

INFANCY PERIOD:

Did the mother have problems with depression after the birth? _____
If so, please briefly describe: _____

Did either parent have significant problems adjusting after the birth? _____ If so, please briefly describe:

INFANCY PERIOD CONTINUED:

Describe any physical or emotional separation from the caretakers in the first few years of life:

_____

Was your child breast fed? _____ Bottle fed? _____

Were any of the following present – to a significant degree – during the first year of life? If so, describe:

_____Did not enjoy cuddling _____
_____Was not calmed by being held _____
_____Difficult to comfort _____
_____Colic _____
_____Excessive restlessness _____
_____Excessive irritability _____
_____Sleep difficulties _____
_____Difficult nursing _____

DEVELOPMENTAL HISTORY:

Motor Development (Sitting, crawling, walking)	Average___	Early____	Late____	Age____
Speech and Language	Average___	Early____	Late____	Age____
Self-Help skills (dressing, brushing, Hygiene, etc.)	Average___	Early____	Late____	Age____
Bowel Trained	Average___	Early____	Late____	Age____
Bladder Trained, Day	Average___	Early____	Late____	Age____
Bladder Trained, Night	Average___	Early____	Late____	Age____
Said alphabet in order	Average___	Early____	Late____	Age____
Began to Read	Average___	Early____	Late____	Age____

BEHAVIOR AND MOOD (INFANCY, TODDLER, PRESCHOOL):

Check all that apply and describe below as necessary:

___overactive/into everything
___under active/passive
___able to play alone
___difficulty with attention
___easy to manage
___adaptable
___deals well with frustration
___difficulty with changes
___stubborn
___curious
___dare-devil
___shy or timid
___affectionate
___playful
___slow to warm up
___easily frustrated
___sad
___obsessive or compulsive
___sensitive
___empathic
___impulsive
___wanted to be left alone
___more interested in things than people
___temper outbursts
___severe tantrums
___difficulties in interactions with others
___sleep difficulties
___eating difficulties
___rocking
___head banging
___staring spells
___breath holding spells
___moody
___happy
___fearful
___angry
___irritable
___aggressive/violent
___stuttering/speech problem
___responds well to challenges
___overwhelmed by challenges
___cautious

BEHAVIOR AND MOOD CONTINUED:
Please describe behaviors or moods that you checked on the previous page:

MEDICAL HISTORY:

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

___hospitalizations _____
___operations _____
___handicaps or deformities _____
___failure to grow _____
___pneumonia _____
___asthma _____
___allergies _____
___skin problems _____
___diabetes _____
___multiple ear infections _____
___tubes placed _____
___seizures _____
___persistent high fevers _____
___obesity _____
___movement problems (tics, repetitive movements, etc.) _____
___head injury (with loss of consciousness) _____
___other physical trauma _____
___coma _____
___encephalitis _____
___eye problems _____
___hearing problems _____
___anemia _____
___stomach problems _____
___constipation _____
___poisoning _____
___other _____ _____

Has your child ever had a neurological evaluation (exam, MRI, CAT Scan, EEG, etc.)? _____
If so, describe: _____
Has vision been tested? ___ Normal? ___ Date? ___
Has hearing been tested? ___ Normal? ___ Date? ___

List medication used in the past for over one month: _____

PRESENT MEDICAL STATUS:

Height _____ Weight_____ Medical Doctor _____
Present illnesses for which the child is being treated _____

PRESENT MEDICAL STATUS CONTINUED:

Date of last physical exam _____ Was blood work done? _____
Describe appetite and diet _____

Medications child is currently taking for medical problems _____

Allergies to medications _____

Frequent physical complaints: (check all that apply)

___Headaches	___Staring into space	___trouble hearing
___dizziness	___tiredness	___chest pain
___sleep problems	___difficulty breathing	___palpitations
___nightmares	___painful urination	___skin problems
___stomach aches	___trouble with vision	___menstrual problems

COORDINATION

Handedness ___ left ___ right ___ both

Rate your child on the following skills:			
	Good	Average	Poor
Walking			
Running			
Throwing			
Catching			
Shoelace tying			
Buttoning			
Writing			
Athletic abilities			

Does your child have an excessive number of accidents compared to other children? ____ If yes, describe
_____

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? _____

If your child tells a story about a show, event, etc. do you or others have difficulty understanding him/her?
If yes, is it because is it because they: (Check all that apply)

___ appear confused	___ are disorganized
___ leave out important information	___ have trouble finding the right words
___ loose train of thought	

COMPREHENSION AND UNDERSTANDING CONTINUED:

Does your child have trouble remembering things that she/he really cares about? _____
Please Describe: _____

Does your child have difficulty following routines (bedtime, dressing, etc.)? ___ Please describe: _____

Does your child frequently loose things or have trouble being organized? ___ Please describe: _____

How would you rate your child's overall level of intelligence compared to other children?
Below average _____ average ____ Above average _____

SCHOOL HISTORY

Did your child attend daycare or preschool? ___ If yes, give approximate number of hours per week._____

What are your current care arrangements for your child before and after school? _____

Has your child experienced any problems in these child care settings (behavioral, developmental, peer related)? ___ If so, please explain: _____

Beginning with kindergarten list school and indicate your child's academic and behavioral performance:							
Grade	School	Academic Performance			Behavioral Performance		
		Poor	Fair	Good	Poor	Fair	Good
KG							
1st							
2nd							
3rd							
4th							
5th							
6th							
7th							
8th							
9th							
10th							
11th							
12th							

Does your child have any known learning disabilities? ____ If yes, please list _____

Has your child been in any special programs (speech, reading, occupational therapy, etc.)? ____ If yes, explain and list grades _____

Has your child ever had to repeat a grade? ____ If yes, please explain: _____

CURRENT ACADEMIC PERFORMANCE

____ Excellent ____Good ____ Satisfactory ____ Unsatisfactory ____ Failing

Does your child enjoy school? _____
School subject strengths: _____
School subject weaknesses: _____

Check any of the following problems your child has with school:

____poor reader
____poor math
____poor spelling
____poor handwriting
____problem with written language
____frequently sent out of class
____does not remain seated
____impulsive
____forgets instructions
____interferes with other's tasks
____requires additional supervision
____talks out inappropriately
____daydreams
____makes careless mistakes
____messy and disorganized
____non-compliant in class
____oppositional with teachers
____skips school
____incomplete classroom work
____excessive time to complete assignments
____test anxiety
____does not do homework
____starts but does not finish homework
____fails to check homework
____difficulties in groups
____difficulties with peers
____poor attention
____frequent suspensions
____expulsions
____aggressive/violent

Is your child involved in extracurricular activities? ____ If yes, please describe:_____

PEER RELATIONSHIPS

Does your child seek friendships with peers? ____
Is your child sought by peers for friendship? ____

Check any of the following which describes your child's interactions with peers:

____No problems
____Cooperative
____Supportive
____Shares well
____Plays well in groups
____Plays primarily with younger children
____Plays primarily with older children
____Rejected by other kids
____No friends
____Loses friends
____Trouble making friends
____Afraid other kids don't like him/her
____Easily led by others
____aggressive or mean
____frequent arguments
____frequent fights
____bossy and controlling
____teasing
____jealous
____involved in risky or dangerous behavior
____bullied by other kids
____involved in alcohol or substance abuse
____involved in delinquent behaviors
____bragging/boastful
____uncooperative
____feelings hurt easily

Make any additional comments regarding your child's interactions with peers: _____

FREE TIME:

Please describe how your child generally spends her/his free time (i.e. plays alone, friends, sports, T.V., video, etc.): _____

Please list approximate number of hours per day your child watches TV and the type of shows watched:

Please list approximate number of hours per day your child plays video games and the type of games played: _____

INDEPENDENT ACTIVITIES:

Please describe your child's ability to function in an independent manner: _____

BEHAVIORS, MOOD, ATTITUDE:

How would you describe your child's conscience?
____normal ____lax ____harsh ____preoccupied with certain issues
Do you have any concerns about your child's self esteem? ____ If yes please describe _____

Do you have any concerns about your child's sexual knowledge or awareness? _____ Gender identity? ___
Sexual orientation?____ If yes, please describe _____

Please check off any of the following that your child has experienced, to a significant degree (currently or in the past):

___Bed wetting
___Soiling
___Sleep problems
___Eating problems
___Significant weight change
___Involuntary vocalizations
___Sexual problems
___Immaturity
___Oppositional, defiant
___Frequent arguing
___lying
___stealing
___cruelty to animals
___fire setting
___suspicious, distrustful
___poor motivation
___change in personality
___strange ideas or behaviors
___hallucinations
___alcohol abuse
___other _____

___fearful
___secretive
___self conscious, embarrassed
___shy, withdrawn
___anxiety, panic
___obsessive compulsive behaviors
___depression
___crying episodes
___extreme moodiness
___irritability, anger
___impulsiveness
___explosive episodes
___aggression, violence
___property destruction
___running away
___trouble with the law
___self destructive behaviors
___suicidal talk or behaviors
___frequent accidents
___guilt
___hopelessness

BEHAVIORS, MOOD, ATTITUDE CONTINUED:

Please express any additional concerns regarding your child _____

Please list your child's strengths (i.e. academic, athletic, personality, creative, funny, etc.) _____

PREVIOUS TREATMENT:

Has your child ever received any type of psychiatric, psychological, or academic evaluation or treatment? If yes, please fill in the following:

Person or Institution	Dates	Address	Phone #

Has your child ever taken psychiatric medications? _____ If yes, please list:

Problem	Medication	Dose	Date started	Date stopped	Side effects	Response

FAMILY HISTORY:

Biological Mother's Name: _____ Age: _____
Occupation: _____ Ethnic Background: _____
Highest Grade Completed: _____

Has the biological mother or any of her blood relatives experienced any of the following psychological or emotional difficulties? (Please check off and list the person who had or has the problem)

____Depression _____
____Suicide or suicide attempts _____
____Anxiety disorders _____
____Psychosis or severe thought problems _____
____Aggressive or violent behaviors _____
____Autism _____
____Mental retardation _____
____Attention difficulties _____
____Learning disabilities _____
____Physical or sexual abuse _____
____Alcohol abuse _____
____Other drug abuse _____
____Social difficulties _____
____Legal trouble _____
____Other _____ _____

FAMILY HISTORY CONTINUED:

Do any medical illnesses run in the biological mother's family? (i.e. thyroid, diabetes, seizures, movement problems such as tics, other neurological problems, allergies, etc.) _____

Any history of miscarriages or abortions? ___ If yes, list date(s) _____

Biological Father's Name: _____ Age: _____
Occupation: _____ Ethnic Background _____
Highest Grade Completed: _____

Has the biological father or any of his blood relatives experienced any of the following psychological or emotional difficulties? (Please check off and list the person who had or has the problem)

____Depression	_____
____Suicide or suicide attempts	_____
____Anxiety disorders	_____
____Psychosis or severe thought problems	_____
____Aggressive or violent behaviors	_____
____Autism	_____
____Mental retardation	_____
____Attention difficulties	_____
____Learning disabilities	_____
____Physical or sexual abuse	_____
____Alcohol abuse	_____
____Other drug abuse	_____
____Social difficulties	_____
____Legal trouble	_____
____Other _____	_____

Do any medical illnesses run in the biological father's family? (i.e. thyroid, diabetes, seizures, movement problems such as tics, other neurological problems, allergies, etc.) _____

How long have the parents been
Married? _____
Separated? _____
Divorced? _____
Living together? _____

If the parents are separated or divorced, please describe custody (physical and legal) and visitation: _____

Please list any previous marriages: _____

Are there currently any significant marital stressors? If so, please briefly explain: _____

FAMILY HISTORY CONTINUED:

Please list siblings:

Name	Age	Blood/step sibling	In Home (Y or N)

Have any of the siblings had any psychological or emotional problems, suicide or suicide attempts, attention or learning difficulties, legal problems, alcohol or substance abuse, social difficulties, or medical problems? If so, please state who and the nature of the problem(s):_____

Other relative or persons living in the home: _____ If yes, please explain: _____

Please list current (or past) significant areas of conflict in the home between your child and others:

Please list the types of discipline you've tried with your child and their effectiveness: _____

Please check any of the following significant events that have occurred within your family and briefly describe:

___death of a family member or close person _____
___significant moves _____
___trauma _____
___divorce/separations _____
___serious illness of a family member _____
___military involvement _____
___parental unemployment _____
___financial stress _____
___trouble with the law _____
___other _____ _____

SPIRITUAL ORIENTATION:

Please list your spiritual orientation or religion: _____
How active are these beliefs in your life?
___Very Active ___Somewhat Active ___Not very Active

Please make any additional comments you wish regarding your child and/or family: