Comprehensive Child History Form

Please complete this form to the best of your knowledge. Please write N/A for questions that are not applicable to your child. If you need more space or wish to make additional comments, please attach a separate sheet of paper. All information is confidential. Please know that by providing these details I gain a better understanding of you and your child and will thus be better equipped to assist you.

GENERAL INFORMATION:

Today's Date: _____
mm/dd/yyyy

Child's legal name: _____
First Middle Last

Nickname: _____ Gender: ☐Male ☐Female

Date of Birth: _____ Age: _____ Grade: _____

Religion: _____ Race/Ethnicity: _____

Language(s) spoken in home: _____

Address: _____

City:_____ State: _____ Zip:_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other Phone: _____

Email Address(es):_____

_____

Name of person completing this form: _____

Relationship to patient:

☐Mother ☐ Father ☐ Grandparent ☐Other: _____

Is child adopted: ☐No ☐Yes (complete the Adopted Child History Form instead of this one)

Parent Name: _____
First Middle Last

Date of Birth: _____ Highest Grade Completed: _____
mm/dd/yyyy

Occupation: _____ Employer: _____

Parent Name: _____
First Middle Last

Date of Birth: _____ Highest Grade Completed: _____
mm/dd/yyyy

Occupation: _____ Employer: _____

Marital status of parents: ☐married ☐never married ☐separated ☐divorced ☐widowed

Additional caregiver(s):

☐None or Name: _____

Relationship (nanny, grandparent, etc.): _____

How much time does this person spend with your child? _____

Who lives in the Child's household?

Name:	*Age:*	*Male / Female*	*Relationship to child:*
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	

Name of pediatrician or family doctor:

Name: _____Phone: _____

Who referred your child to me?

Name: _____Phone: _____

Please list the names of other professionals consulted prior to coming to see me:

Name:	*Type of Professional:*	*When consulted:*

CURRENT CONCERNS:

Please check the areas below that you have concerns about your child.

☐ short attention span	☐ attention seeking	☐ distractibility
☐ impulsivity	☐ hyperactivity	☐ avoidance
☐ low frustration tolerance	☐ noncompliance	☐ skipping school
☐ oppositional behavior	☐ social isolation	☐ anxiety
☐ aggression	☐ lying	☐ stealing
☐ setting fires	☐ obsessive/compulsive behaviors	☐ cruelty to animals
☐ sensitive to environment	☐ temper tantrums	☐ cries easily
☐ overly shy	☐ difficulty with transition	☐ clingy to parent

Please explain checked boxes: _____

_____

Do you have any other concerns not listed above? _____

_____

Briefly describe your current concerns: _____

_____

When did you first notice these problems? _____

_____

PRE-NATAL HISTORY:

Was this child the product of a planned pregnancy? ☐ Yes ☐ No

Did either parent take medication or fertility drugs to become pregnant? ☐ Yes ☐ No

(if yes, please list medication: _____)

Were other medical procedures used to become pregnant with this child? ☐ Yes ☐ No

(if yes, please explain: _____)

How many full-term pregnancies has mother had? _____

(please list dates: _____)

Has mother experienced any miscarriages, abortions, or stillbirths? ☐ Yes ☐ No

(please list dates: _____)

Were the parents married at the time this child was conceived: ☐ Yes ☐ No

Length of parents' relationship at the time this child was conceived: _____

Are the parents currently together? ☐ Yes ☐ No

Check Yes / No for the items below which may have occurred during pregnancy:

Yes	No		Yes	No	
☐	☐	Edema (swelling)	☐	☐	Accidents / Injuries
☐	☐	Vaginal bleeding	☐	☐	Breathing difficulties
☐	☐	Toxemia	☐	☐	Alcohol used
☐	☐	Emotional stress	☐	☐	Cigarettes used
☐	☐	High blood pressure	☐	☐	Abnormal weight gain
☐	☐	Infections (cold, flu, urinary)	☐	☐	Pre-term labor
☐	☐	Fever	☐	☐	Hospitalization
☐	☐	Medication used	☐	☐	Diabetes
☐	☐	Operations/Surgeries	☐	☐	Other (explain below)

Please explain all "yes" answers: _____

_____

BIRTH HISTORY:

Where was the baby born? (city/state/country) _____

Was the baby on time? ☐ Yes ☐ No

If no, was he/she ☐ early or ☐ late? By how many weeks? _____

Weight of child at birth: _____ Apgar scores (if known): _____

Age of mother at birth: _____ Age of father at birth: _____

Does either parent have children from previous relationships? ☐ Yes ☐ No

If yes, please list names and ages of children and parent:

_____

Check all that apply:

☐ Spontaneous labor	☐ Vaginal delivery
☐ Induced labor	☐ C-section (planned? ☐ yes ☐ no)
☐ Breech presentation	☐ VBAC (vaginal birth after c-section)
☐ Toxemia/Eclampsia	☐ Fetal distress
☐ Maternal fever	☐ Medication used

Please add any comments regarding the items noted above: _____

_____

POST-DELIVERY PERIOD:

How many days did the baby stay in the hospital after birth? _____

How many days did the mother stay in the hospital after delivery? _____

Check Yes / No for the items which may have occurred during the days following the child's birth:

Yes	No		Yes	No	
☐	☐	Difficulty breathing	☐	☐	Infection
☐	☐	Need for ventilation	☐	☐	Jaundice
☐	☐	Blood transfusion	☐	☐	Poor feeding
☐	☐	Bleeding in head	☐	☐	Vomiting / Reflux
☐	☐	Water on the brain	☐	☐	Floppy muscle tone
☐	☐	Turned blue	☐	☐	Neonatal ICU (NICU)
☐	☐	Fever	☐	☐	Other (explain below)

Please explain all "yes" answers: _____

_____

DEVELOPMENT:

Was your child breast-fed? ☐ Yes ☐ No

If yes, from age _____ until age _____

when did breast feeding stop? _____

describe the circumstances around stopping: _____

describe the weaning process: _____

Was your child bottle-fed? ☐ Yes ☐ No

If yes, from age _____ until age _____

when did bottle feeding stop? _____

describe the circumstances around stopping: _____

describe the weaning process: _____

Did your child have colic? ☐ Yes ☐ No

If yes, from when to when? _____

Did your child experience any feeding problems? ☐ Yes ☐ No

If yes, please describe: _____

Does your child experience any feeding problems now? ☐ Yes ☐ No

If yes, please describe: _____

Check Yes / No for the items below which may have occurred during the first few years of life:

Yes	No		Yes	No	
☐	☐	Difficult to comfort	☐	☐	Sleep difficulties
☐	☐	Excessive irritability	☐	☐	Excessive restlessness
☐	☐	Extremely passive	☐	☐	Frequent head banging
☐	☐	Always had to be held	☐	☐	Other (_____)

Please explain all "yes" answers: _____

_____

Please complete the chart below regarding your child's accomplishment of early developmental milestones:

Milestone	*Age milestone accomplished*	*Did you feel this was:*
Smiled (social smile)		☐ On Time ☐ Early ☐ Late
Laughed		☐ On Time ☐ Early ☐ Late
Rolled over		☐ On Time ☐ Early ☐ Late
Sat independently		☐ On Time ☐ Early ☐ Late
Crawled independently		☐ On Time ☐ Early ☐ Late
Stood independently		☐ On Time ☐ Early ☐ Late
Walked independently		☐ On Time ☐ Early ☐ Late
Waved bye-bye		☐ On Time ☐ Early ☐ Late
Toilet trained (urine)		☐ On Time ☐ Early ☐ Late
Toilet trained (bowel)		☐ On Time ☐ Early ☐ Late
Spoke first words		☐ On Time ☐ Early ☐ Late
Put two words together		☐ On Time ☐ Early ☐ Late

What were your child's first words? _____

Could <u>you</u> understand your child's speech by age 2 years? ☐ Yes ☐ No

Could <u>others</u> understand your child's speech by age 2 years? ☐ Yes ☐ No

Could your child speak in simple sentences by age 2 years? ☐ Yes ☐ No

How does your child typically communicate now: ☐ gesture ☐ words ☐ sentences

What are your child's sleeping arrangements? ☐ Room alone ☐ With sibling ☐ Parents room ☐ Other

Where does your child sleep? ☐ Crib ☐ Bed ☐ Parents bed ☐ Other (describe: _____)

Is it difficult for your child to go to sleep? ☐ No ☐ Yes

How long does it take him/her to fall asleep? _____

Do you have a regular bedtime routine? ☐ No ☐ Yes (describe: _____)

Does your child wake up during the night? ☐ No ☐ Yes (how many times? _____)

How long does he/she stay awake? _____ What helps him/her go back to sleep? _____

Is your child a restless sleeper? ☐ Yes ☐ No

Does (Did) your child have a special object (blanket, teddy bear, etc.)?

☐ No ☐ Yes, describe: _____ Until age: _____

Does (Did) your child have any self-soothing behavior (e.g., suck thumb, pacifier, twirl hair, etc.)?

☐ No ☐ Yes, describe: _____ Until age: _____

How many hours of screen time (TV, video games, etc.) does your child have each day? _____

What are his/her favorites? _____

TEMPERAMENT:

I would like to get a sense of how you would describe your child's temperament. Please describe his/her temperament using adjectives below:

1) _____ 2) _____ 3) _____

Check the type of discipline you use with your child:

☐ Rewards	☐ Verbal reprimands
☐ Time out (isolation)	☐ Removal of privileges
☐ Avoidance of child	☐ Physical punishment
☐ Other (describe: _____)	

Which form of discipline has proven most effective? _____

How often must you discipline your child? _____

What is the most common reason you discipline your child? _____

Does your child have any close friends? ☐ No ☐ Yes (how many? _____)

How does your child get along with his/her peers? ☐ well ☐ average ☐ poor

How well does your child make new friends? ☐ well ☐ average ☐ poor

Does your child get along best with children: ☐ older ☐ same age ☐ younger

Please add any comments regarding your child's peer relationships: _____

_____

Please check if your child is:

☐ loud and noisy	☐ easily angered	☐ able to entertain him/herself
☐ sensitive to sound	☐ shy with new adults	☐ affectionate
☐ sensitive to touch	☐ shy with new children	☐ aggressive
☐ sensitive to light	☐ physically cautious	☐ sluggish/slow moving
☐ sensitive to smell	☐ a dangerous risk taker	☐ overly active

Please explain all above checked boxes: _____

_____

What are your child's favorite activities? _____

_____

What are your child's <u>least</u> favorite activities? _____

_____

Describe your child's typical mood: _____

_____

What about your child makes you most proud? _____

_____

CHILD'S HEALTH HISTORY:

Check Yes / No for the items below which your child may have experienced:

Yes	No		Yes	No	
☐	☐	Vision problems	☐	☐	Pica (eating nonfood items)
☐	☐	Hearing problems	☐	☐	Excessive vomiting
☐	☐	Asthma	☐	☐	Head trauma
☐	☐	Allergies	☐	☐	Loss of consciousness
☐	☐	Stomach aches	☐	☐	Coma
☐	☐	Sleep problems	☐	☐	Seizures
☐	☐	Bed-wetting	☐	☐	Tics
☐	☐	Stool soiling	☐	☐	Staring spells
☐	☐	Chronic ear infections	☐	☐	Tremor
☐	☐	Hospitalization	☐	☐	Frequent falls
☐	☐	Surgery	☐	☐	Anemia
☐	☐	Broken bones, stitches	☐	☐	Persistent high fever
☐	☐	Accidental poisoning	☐	☐	Headaches
☐	☐	Floppy muscle tone	☐	☐	Other problems (explain)

Please explain all "yes" answers: _____

_____

Do you have any particular concerns regarding your child's physical health? ☐ Yes ☐ No

If yes, please explain: _____

Does your child currently take medication? ☐ No ☐ Yes, list: _____

List any medications your child has taken in the past: _____

When was your child's last physical exam? _____ Where? _____

Please check if your child has had any of the following or ☐ None

☐ Individual Psychotherapy	☐ Group Psychotherapy	☐ Occupational Therapy
☐ Physical Therapy	☐ Speech Therapy	☐ Developmental Evaluation
☐ Educational Evaluation	☐ Brain scan (CT or MRI)	☐ EEG testing
☐ Genetic/Chromosome tests	☐ Lead testing	☐ Other (explain below)

Please explain all checked boxes including dates, providers, and results: _____

_____

_____

FAMILY HEALTH HISTORY:

Check Yes / No for each item below that may apply to a family member and then state relation (e.g., mother, brother, paternal uncle, maternal cousin, etc.)

Yes	*No*		*Relation to child:*
☐	☐	Heart Disease	
☐	☐	Cancer	
☐	☐	Vision Problems	
☐	☐	Hearing Problems	
☐	☐	Epilepsy/Seizures	

Yes	*No*		*Relation to child:*
☐	☐	Birth Defects	
☐	☐	Cerebral Palsy	
☐	☐	Genetic Condition	
☐	☐	Muscle/Motor Problem	
☐	☐	Other (describe: _____)	

Please add any relevant details you feel are important regarding items above: _____

_____

Are there any other health issues that run in the family? ☐ No ☐ Yes, explain:

_____

FAMILY EMOTIONAL AND LEARNING HISTORY:

Check Yes / No for each item below that may apply to a family member and then state relation (e.g., mother, brother, paternal uncle, maternal cousin, etc.)

Yes	*No*		*Relation to child:*
☐	☐	Depression	
☐	☐	Substance Abuse	
☐	☐	Alcoholism	
☐	☐	Hyperactivity/ADHD	
☐	☐	Oversensitive to Sound/Touch/Taste/Smell	
☐	☐	Learning Problems	
☐	☐	Autism Spectrum Disorder	
☐	☐	Speech Problems/Delays	
☐	☐	Eating Problems (Anorexia, Bulimia)	
☐	☐	Post-Partum Depression	
☐	☐	Mental Retardation	
☐	☐	Phobias/Fears	
☐	☐	Down Syndrome	
☐	☐	Anxiety	
☐	☐	Schizophrenia	
☐	☐	Obsessive Compulsive Disorder (OCD)	
☐	☐	Bipolar Disorder (Manic Depression)	
☐	☐	Other (describe: _____)	

Please add any relevant details you feel are important regarding items above: _____

_____

Has any biological relative to your child experienced problems similar to those your child is currently experiencing? ☐ No ☐ Yes (explain:_____)

RECENT STRESSFUL EVENTS AND SUPPORT:

Please check if either parent has experienced any of the following or ☐ None

☐ Major accident/illness ☐ Moving homes ☐ Loss of significant other

☐ Financial setback ☐ Loss of family member/friend ☐ Difficulty as a couple

☐ Separation from child ☐ Therapy/counseling ☐ Other (explain: _____)

Please explain all checked boxes (What happened? When? What support did you have? How did you deal with it?): _____

_____

_____

_____

Please check if your child has experienced any of the following or ☐ None

☐ Separation from parent ☐ Moving homes ☐ Addition of new sibling

☐ Major accident/illness ☐ Loss of family member/friend ☐ Other (explain: _____)

Please explain all checked boxes (What happened? When? How did your child react?):

_____

_____

_____

_____

SCHOOL/EDUCATION HISTORY:

Does your child attend school/preschool/daycare? ☐No ☐ Yes

Name of child's current school/preschool/daycare: _____

Address: _____

Telephone: _____ Teacher: _____ Grade: _____

Director: _____ Special Placement (if any): _____

Please list the following information for each school/preschool/daycare your child has attended:

Name	*Age at entry*	*Begin date*	*End date*	*Hours per day & Days per week*

Please check all that apply to your child's preschool / daycare / school experience or ☐ None

☐ Adjustment problems	☐ Negative reaction to school	☐ Services through ECI
☐ Services through PPCD	☐ Services at school (speech, OT)	☐ Extra support in classroom
☐ Pull-outs (reading, math)	☐ School completed testing	☐ IEP or ARD
☐ Retained a grade	☐ Asked to leave school/program	☐ Suspended from school
☐ Expelled from school	☐ Performance below peer level	☐ Other (explain: _____)

Please explain all checked boxes:

_____

_____

_____

ADDITIONAL INFORMATION:

Please add any additional information you think is relevant or address any concerns not addressed above:

_____

_____

_____

_____

_____

_____

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