

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?

<i>Name:</i>	<i>Age:</i>	<i>Male / Female</i>	<i>Relationship to child:</i>
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> 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:

<i>Name:</i>	<i>Type of Professional:</i>	<i>When consulted:</i>

CURRENT CONCERNS:

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

- | | | |
|---|---|---|
| <input type="checkbox"/> clingy to parent | <input type="checkbox"/> attention seeking | <input type="checkbox"/> easily distracted |
| <input type="checkbox"/> impulsivity | <input type="checkbox"/> hyperactivity | <input type="checkbox"/> avoidance |
| <input type="checkbox"/> low frustration tolerance | <input type="checkbox"/> noncompliance | <input type="checkbox"/> overly shy |
| <input type="checkbox"/> oppositional behavior | <input type="checkbox"/> social isolation | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> aggression | <input type="checkbox"/> lying | <input type="checkbox"/> stealing |
| <input type="checkbox"/> difficulty with transition | <input type="checkbox"/> obsessive/compulsive behaviors | <input type="checkbox"/> cruelty to animals |
| <input type="checkbox"/> sensitive to environment | <input type="checkbox"/> temper tantrums | <input type="checkbox"/> cries easily |

Please explain checked boxes: _____

Describe any concerns not listed above: _____

When did you first notice these problems? _____

What do you hope to address by coming to see Dr. Forrester? _____

Note specific services (if any) you are seeking: _____

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	
<input type="checkbox"/>	<input type="checkbox"/>	Edema (swelling)	<input type="checkbox"/>	<input type="checkbox"/>	Accidents / Injuries
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Breathing difficulties
<input type="checkbox"/>	<input type="checkbox"/>	Toxemia	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol used
<input type="checkbox"/>	<input type="checkbox"/>	Emotional stress	<input type="checkbox"/>	<input type="checkbox"/>	Cigarettes used
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal weight gain
<input type="checkbox"/>	<input type="checkbox"/>	Infections (cold, flu, urinary)	<input type="checkbox"/>	<input type="checkbox"/>	Pre-term labor
<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization
<input type="checkbox"/>	<input type="checkbox"/>	Medication used	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Operations/Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	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:

- | | |
|--|--|
| <input type="checkbox"/> Spontaneous labor | <input type="checkbox"/> Vaginal delivery |
| <input type="checkbox"/> Induced labor | <input type="checkbox"/> C-section (planned? <input type="checkbox"/> yes <input type="checkbox"/> no) |
| <input type="checkbox"/> Breech presentation | <input type="checkbox"/> VBAC (vaginal birth after C-section) |
| <input type="checkbox"/> Toxemia/Eclampsia | <input type="checkbox"/> Fetal distress |
| <input type="checkbox"/> Maternal fever | <input type="checkbox"/> 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	
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Infection
<input type="checkbox"/>	<input type="checkbox"/>	Need for ventilation	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Poor feeding
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding in head	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting / Reflux
<input type="checkbox"/>	<input type="checkbox"/>	Water on the brain	<input type="checkbox"/>	<input type="checkbox"/>	Floppy muscle tone
<input type="checkbox"/>	<input type="checkbox"/>	Turned blue	<input type="checkbox"/>	<input type="checkbox"/>	Neonatal ICU (NICU)
<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	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	
<input type="checkbox"/>	<input type="checkbox"/>	Difficult to comfort	<input type="checkbox"/>	<input type="checkbox"/>	Sleep difficulties
<input type="checkbox"/>	<input type="checkbox"/>	Excessive irritability	<input type="checkbox"/>	<input type="checkbox"/>	Excessive restlessness
<input type="checkbox"/>	<input type="checkbox"/>	Extremely passive	<input type="checkbox"/>	<input type="checkbox"/>	Frequent head banging
<input type="checkbox"/>	<input type="checkbox"/>	Always had to be held	<input type="checkbox"/>	<input type="checkbox"/>	Other (_____)

Please explain all "yes" answers: _____

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

<i>Milestone</i>	<i>Age milestone accomplished</i>	<i>Did you feel this was:</i>
Smiled (social smile)		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Laughed		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Rolled over		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Sat independently		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Crawled independently		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Stood independently		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Walked independently		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Waved bye-bye		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Toilet trained (urine)		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Toilet trained (bowel)		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Spoke first words		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late
Put two words together		<input type="checkbox"/> On Time <input type="checkbox"/> Early <input type="checkbox"/> Late

What were your child's first words? _____

Could you understand your child's speech by age 2 years? Yes No

Could others 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:

<input type="checkbox"/> Rewards	<input type="checkbox"/> Verbal reprimands
<input type="checkbox"/> Time out (isolation)	<input type="checkbox"/> Removal of privileges
<input type="checkbox"/> Avoidance of child	<input type="checkbox"/> Physical punishment
<input type="checkbox"/> 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:

- | | | |
|---|---|--|
| <input type="checkbox"/> loud and noisy | <input type="checkbox"/> easily angered | <input type="checkbox"/> able to entertain him/herself |
| <input type="checkbox"/> sensitive to sound | <input type="checkbox"/> shy with new adults | <input type="checkbox"/> affectionate |
| <input type="checkbox"/> sensitive to touch | <input type="checkbox"/> shy with new children | <input type="checkbox"/> aggressive |
| <input type="checkbox"/> sensitive to light | <input type="checkbox"/> physically cautious | <input type="checkbox"/> sluggish/slow moving |
| <input type="checkbox"/> sensitive to smell | <input type="checkbox"/> a dangerous risk taker | <input type="checkbox"/> overly active |

Please explain all above checked boxes: _____

What are your child's favorite activities? _____

What are your child's least 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:

<input type="checkbox"/>	<input type="checkbox"/>	Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	Pica (eating nonfood items)
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	Excessive vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Head trauma
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Loss of consciousness
<input type="checkbox"/>	<input type="checkbox"/>	Stomach aches	<input type="checkbox"/>	<input type="checkbox"/>	Coma
<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	Tics
<input type="checkbox"/>	<input type="checkbox"/>	Stool soiling	<input type="checkbox"/>	<input type="checkbox"/>	Staring spells
<input type="checkbox"/>	<input type="checkbox"/>	Chronic ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Tremor
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	Frequent falls
<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Broken bones, stitches	<input type="checkbox"/>	<input type="checkbox"/>	Persistent high fever
<input type="checkbox"/>	<input type="checkbox"/>	Accidental poisoning	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Floppy muscle tone	<input type="checkbox"/>	<input type="checkbox"/>	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

<input type="checkbox"/> Individual Psychotherapy	<input type="checkbox"/> Group Psychotherapy	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Developmental Evaluation
<input type="checkbox"/> Educational Evaluation	<input type="checkbox"/> Brain scan (CT or MRI)	<input type="checkbox"/> EEG testing
<input type="checkbox"/> Genetic/Chromosome tests	<input type="checkbox"/> Lead testing	<input type="checkbox"/> 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:
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	
<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	

<i>Yes</i>	<i>No</i>		<i>Relation to child:</i>
<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects	
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	
<input type="checkbox"/>	<input type="checkbox"/>	Genetic Condition	
<input type="checkbox"/>	<input type="checkbox"/>	Muscle/Motor Problem	
<input type="checkbox"/>	<input type="checkbox"/>	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.)

<i>Yes</i>	<i>No</i>		<i>Relation to child:</i>
<input type="checkbox"/>	<input type="checkbox"/>	Depression	
<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	
<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity/ADHD	
<input type="checkbox"/>	<input type="checkbox"/>	Oversensitive to Sound/Touch/Taste/Smell	
<input type="checkbox"/>	<input type="checkbox"/>	Learning Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Autism Spectrum Disorder	
<input type="checkbox"/>	<input type="checkbox"/>	Speech Problems/Delays	
<input type="checkbox"/>	<input type="checkbox"/>	Eating Problems (Anorexia, Bulimia)	
<input type="checkbox"/>	<input type="checkbox"/>	Post-Partum Depression	
<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation	
<input type="checkbox"/>	<input type="checkbox"/>	Phobias/Fears	
<input type="checkbox"/>	<input type="checkbox"/>	Down Syndrome	
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	
<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia	
<input type="checkbox"/>	<input type="checkbox"/>	Obsessive Compulsive Disorder (OCD)	
<input type="checkbox"/>	<input type="checkbox"/>	Bipolar Disorder (Manic Depression)	
<input type="checkbox"/>	<input type="checkbox"/>	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

- | | | |
|---|---|--|
| <input type="checkbox"/> Major accident/illness | <input type="checkbox"/> Moving homes | <input type="checkbox"/> Loss of significant other |
| <input type="checkbox"/> Financial setback | <input type="checkbox"/> Loss of family member/friend | <input type="checkbox"/> Difficulty as a couple |
| <input type="checkbox"/> Separation from child | <input type="checkbox"/> Therapy/counseling | <input type="checkbox"/> 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

- | | | |
|---|---|--|
| <input type="checkbox"/> Separation from parent | <input type="checkbox"/> Moving homes | <input type="checkbox"/> Addition of new sibling |
| <input type="checkbox"/> Major accident/illness | <input type="checkbox"/> Loss of family member/friend | <input type="checkbox"/> 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:

<i>Name</i>	<i>Age at entry</i>	<i>Begin date</i>	<i>End date</i>	<i>Hours per day & Days per week</i>

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Adjustment problems | <input type="checkbox"/> Negative reaction to school | <input type="checkbox"/> Services through ECI |
| <input type="checkbox"/> Services through PPCD | <input type="checkbox"/> Services at school (speech, OT) | <input type="checkbox"/> Extra support in classroom |
| <input type="checkbox"/> Pull-outs (reading, math) | <input type="checkbox"/> School completed testing | <input type="checkbox"/> IEP or ARD |
| <input type="checkbox"/> Retained a grade | <input type="checkbox"/> Asked to leave school/program | <input type="checkbox"/> Suspended from school |
| <input type="checkbox"/> Expelled from school | <input type="checkbox"/> Performance below peer level | <input type="checkbox"/> 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:

(Rev. 06122017)