

CHILD HISTORY

For Office Use Only: Interview held on

from to with

Notes

Child's name: _____ Date: _____
Address: _____ Date of birth: _____ Age: _____
Sex: Male Female Other
Home phone: _____ Work phone: _____
Cell phone/other phone: _____ Email: _____
Name of person completing form: _____ Relationship to child: _____
Child's primary care physician, address, and phone: _____

Referral Information

Who referred you for an evaluation/psychological services? _____
What are you hoping to gain from these services? _____

In your opinion, what is the major cause of this child's difficulties? _____

Describe some of this child's strengths: _____

Describe some of this child's weaknesses: _____

Do caregivers agree about the nature and causes of the problem? _____

Pregnancy and Birth History

Child is: biological adopted (at age _____) foster

Was this child a planned pregnancy? No Yes

Was the mother under a doctor's care? No Yes

Number of previous pregnancies: _____ miscarriages: _____

Check any of the following health complications during the pregnancy.

- | | | |
|--|---|---|
| <input type="checkbox"/> Fertility problems | <input type="checkbox"/> Vaginal bleeding | <input type="checkbox"/> Toxemia |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Fever/rash (e.g., flu, measles) | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Abnormal weight gain |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive swelling | <input type="checkbox"/> Excessive vomiting |
| <input type="checkbox"/> Blood incompatibility | <input type="checkbox"/> Smoking | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Illicit drugs | <input type="checkbox"/> Medications | <input type="checkbox"/> Other: _____ |
- Hospitalization during pregnancy: Reason: _____
- X-rays during pregnancy: What month? _____
- List any medications, tobacco use, alcohol use, or other drugs during pregnancy: _____

Age of mother: _____ and father: _____ at delivery Age of mother at birth of first child: _____
Birth weight: _____ lbs. _____ oz. Length of pregnancy: _____ weeks
Length of labor: _____ hours Apgar scores: _____
Delivery was: vaginal Cesarean (reason _____)

Check any of the following complications during birth.

Breech birth Cord around neck Meconium staining
 Lacking oxygen Forceps used Labor induced
 Other: Describe: _____

Jaundiced: Bilirubin lights? No Yes If yes, how long? _____

Did baby breathe spontaneously? No Yes Oxygen required? No Yes

Length of stay in hospital: Mother: _____ days Child: _____ days

Medical problems after discharge (e.g., jaundice, fever, transfusion, surgery)? _____

Any problems in first few months? No Yes Explain: _____

Did mother experience postpartum (after birth) depression? No Yes

Describe this child's temperament as an infant: _____

Developmental History

Motor

Age sat alone: _____ crawled: _____ stood alone: _____ walked alone: _____

Was this child slow to develop motor skills or awkward compared to siblings/friends (e.g., running, skipping, climbing, playing ball, handwriting)? _____

Handedness: right left both (explain) _____

History of physical therapy? When? _____

History of occupational therapy? When? _____

Speech/Language

Age spoke first word: _____ put 2-3 words together: _____ spoke in sentences: _____

Oral motor problems (e.g., late drooling, poor sucking, poor chewing)? Describe: _____

Speech delay/problems (e.g., stutters, difficult to understand)? _____

History of speech/language therapy? When? _____

Was this child slow to: learn alphabet? name colors? count?

Other language spoken in home (besides English)? _____

Toileting

Age when toilet trained: _____

Problems with bed wetting? Until what age? _____

Urine accidents? Until what age? _____

Soiling accidents? Until what age? _____

Current wetting or soiling problems? Explain: _____

How old was this child when you first became concerned about his/her social/emotional/behavioral functioning? _____

Medical History

Check any that apply and indicate age.

- | | | |
|--|--|--|
| <input type="checkbox"/> Failure to thrive | <input type="checkbox"/> Febrile seizures | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Staring spells | <input type="checkbox"/> Lead poisoning | <input type="checkbox"/> Toxic ingestion |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Urination problems | <input type="checkbox"/> Accident prone |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Tics/twitching | <input type="checkbox"/> Repetitive movements | <input type="checkbox"/> Impulsivity |
| <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Nail biting | <input type="checkbox"/> Clumsiness |
| <input type="checkbox"/> Head banging | <input type="checkbox"/> Self-injurious behavior | <input type="checkbox"/> Rocks back and forth |

Has vision been checked? No Yes Any problems? _____

Has hearing been checked? No Yes Any problems? _____

History of ear tubes? No Yes

List serious illnesses/injuries/hospitalizations/surgeries.

Incident (explain)

Age

Check if any of the following have been performed (list dates).

CT _____ MRI _____ EEG _____

List results of these or other tests: _____

Describe head injuries (e.g., date, type, loss of consciousness, associated symptoms): _____

Current medications/supplements and reasons: _____

Is there a family history of (list problems and relationships of family members):
learning or attention problems? _____

psychiatric problems (e.g., depression, anxiety, schizophrenia, other mental illness)? _____

alcoholism or substance abuse? _____

autism spectrum disorder or intellectual disability? _____

neurological illness (e.g., Alzheimer's disease, Huntington's chorea, Parkinson's disease, epilepsy)? _____

other medical illness (e.g., high blood pressure, cancer, diabetes, migraine headaches, heart disease)? _____

Does anyone else in the family have a problem similar to this child's reason for referral? _____

Family Information

Parent/Caregiver name: _____ age: _____ education: _____

Occupation: _____ Employer: _____

Parent/Caregiver name: _____ age: _____ education: _____

Occupation: _____ Employer: _____

Parents are: married separated divorced never married

Describe the nature of the current relationship between the parents (e.g., loving, friendly, civil, conflictual, volatile): _____

Do the parents generally agree on child rearing strategies (e.g., discipline)? No Yes

Is this child closer to one parent than another? No Yes If yes, which? _____

If divorced, who has custody of this child? _____

Describe the visitation arrangements: _____

List all brothers and sisters, and any other members of the household(s).

Age	Sex	Name/relationship to this child	Living at home?	Problems?
-				
-				
-				
-				
-				
-				

Is this child in a child-care setting? No Yes How many hours/day? _____

Has this child ever experienced death or separation from a loved one? No Yes

Explain: _____

Social History

Does this child:

- | | |
|--|--|
| have difficulty relating to or playing with other children? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| interact better with adults than children his/her own age? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| have difficulty making/keeping friends? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| understand gestures? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| have a good sense of humor? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| understand social cues well (e.g., knows when others are angry)? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| have problems with peer pressure (e.g., alcohol or drug use)? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| show a desire to please you? | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Adaptive Functioning

Please list any chores or responsibilities this child has at home: _____

Describe screen media use: _____

Psychological History

Please describe this child's typical mood: _____

List any previous direct contact with any social agency, psychologist, or psychiatrist.

Name and type of professional

Reason for services

Dates

Academic History

Current school and address: _____

Grade: _____ Placement: regular resource special education other

Any grades that were skipped or repeated? No Yes Explain: _____

Check any of the following teachers have reported problems in.

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Attention/concentration |
| <input type="checkbox"/> Spelling | <input type="checkbox"/> Behavior |
| <input type="checkbox"/> Arithmetic | <input type="checkbox"/> Social adjustment |
| <input type="checkbox"/> Writing | |

Describe any academic problems.

Preschool _____

Kindergarten _____

Early elementary school (1st to 2nd) _____

Upper elementary school (3rd to 5th) _____

Middle school (6th to 8th) _____

High school _____

Has this child been tested for special education? No Yes Results: _____

Does this child have an IEP? No Yes If so, describe services: _____

Additional Comments
