

HISTORY FORM

Date: _____ / _____ / _____
Month Day Year

Child's Name: _____
Last First Middle

Date of Birth: _____ / _____ / _____ Race: _____
Month Day Year

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____
(Area Code) Number

Who referred your child for an evaluation?

Reason you are requesting this evaluation?

Circumstances/factors you think are important regarding this reason?

In my opinion, the major cause of my child's difficulties is

Describe your child's strengths

Describe your child's weaknesses

Child is: right-handed left-handed
 ambidextrous hand preference not yet established

Child's present primary care physician:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone #: _____
 (Area Code) Number

FAMILY BACKGROUND

Child currently lives with:

- both natural parents
- natural mother only
- natural mother and stepfather
- adoptive parents
- relatives: please specify _____
- institution: please specify _____
- natural father only
- natural father and stepmother
- foster parents

Please provide the following information about the child's siblings:

Name	Date of Birth	Gender	Current Grade Level	Diagnoses/Concerns

Please tell us who else lives in the home? (aunts, uncles, grandparents, nonrelatives, etc.)

Name	Relationship to Child

Please provide the following information regarding the child's natural mother and father:

Name	Current Occupation	Educational Level Completed

HEALTH HISTORY

Please check any conditions listed below that apply to relatives of the child. Next to it, please write that person's relationship to the child. Relatives include the child's brothers, sisters, parents, grandparents, aunts, uncles and cousins on both sides of the family.

<u>Condition</u>	<u>Relationship to Child</u>
<input type="checkbox"/> Seizures, convulsions, epilepsy	_____
<input type="checkbox"/> Cerebral palsy	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Muscular weakness	_____
<input type="checkbox"/> Poor coordination, clumsy	_____
<input type="checkbox"/> Slow motor development	_____
<input type="checkbox"/> Deformities	_____
<input type="checkbox"/> Early deaths	_____
<input type="checkbox"/> Severe visual impairment	_____
<input type="checkbox"/> Hearing loss	_____
<input type="checkbox"/> Speech problems or late talker	_____
<input type="checkbox"/> Minimal brain dysfunction	_____
<input type="checkbox"/> Mental retardation	_____
<input type="checkbox"/> Slow development	_____

<u>Condition</u>	<u>Relationship to Child</u>
<input type="checkbox"/> Brain damage	_____
<input type="checkbox"/> School difficulties	_____
<input type="checkbox"/> Reading difficulty	_____
<input type="checkbox"/> Learning disabilities	_____
<input type="checkbox"/> Emotional/behavioral problems	_____
<input type="checkbox"/> Attention deficit disorder	_____
<input type="checkbox"/> Autism, PDD, Asperger's	_____
<input type="checkbox"/> Psychiatric disorder	_____
<input type="checkbox"/> Odd social/eccentric personality	_____
<input type="checkbox"/> Tics or sudden unplanned movements	_____
<input type="checkbox"/> Tourette's Syndrome	_____
<input type="checkbox"/> Neurofibromatosis	_____
<input type="checkbox"/> Tuberous sclerosis	_____
<input type="checkbox"/> Fragile X	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Immune system problems (rhumatoid arthritis, lupus, etc.)	_____
<input type="checkbox"/> Thyroid disease	_____
<input type="checkbox"/> Kidney disease	_____
<input type="checkbox"/> Heart disease	_____
<input type="checkbox"/> Heavy drinking	_____
<input type="checkbox"/> Other (please specify)	_____

CHILD'S MEDICAL INFORMATION

Pregnancy:

Duration: _____ weeks

Complications:

- None
- Excessive nausea and vomiting
- Threatened miscarriage
- RH incompatibility
- High blood pressure
- Emotional strain
- Smoked during pregnancy; # of cigarettes per day: _____
- Hospitalization required before due date
- Spotting or bleeding
- Accidents
- Anemia
- Toxemia

- Infectious diseases during pregnancy: *please specify:*

- Medical problems not related to pregnancy: *please specify:*

- Medications taken during pregnancy: *please specify:*

- an occasional drink or cigarette:

- Other information about pregnancy: *please specify:*

DELIVERY

- Spontaneous
- Induced
- Caesarian Section
- Vaginal

Length of labor: _____ hours Birth weight: _____ lbs. _____ oz.

Complications:

- None
- Multiple births:
- Breech
- Twins
- Forceps
- Triplets
- Cord around neck
- Other

- Other birth complications, *please specify:*

Total number of days your child was in hospital after delivery: _____

NEWBORN

Please check any of the following that applied during the first month:

- Active and alert
- Skin normal color
- Skin yellow (jaundice): transfusion? Yes No
- Skin blue (cyanosis)
- Feeding problems
- Vomiting
- Diarrhea
- Seizures/convulsions
- Unusual appearance
- Breathed right away; *if delayed, how long?* _____
- Incubator: *if so, how long?* _____
- Cried right away: *if delayed, how long?* _____
- Infection: *please specify:* _____
- Injury: *please specify:* _____
- Birth defects: *please specify:* _____

CHILD'S MEDICAL HISTORY

Please provide the following information about the child's medical history:

Childhood Illness and Diseases			
Date (mm/year)	Child's Age	Treatment Received	Outcome

Hospitalizations and Operations			
Date (mm/year)	Child's Age	Reason	Outcome

Please check any of following that apply to your child:

- Issues with vision
- Allergies
- Seizures/convulsions
 - With fever?
 - Without fever?
- Strep throat/streptococcal infection?
Age of child: _____
- Lead exposure (elevated blood levels)
- Frequent ear infections
Approximately how many: _____
Treated by: medication
 insertion of PE tubes
- Issues with hearing
Has hearing been checked? Yes No

If so, was the hearing examination:
 Brainstem evoked auditory responses (BAER)
 Sound field or with earphones
 Tympanometry

Results: normal impaired

Issues with sleeping. If so, child's age: _____ *Please describe:*

Issues with eating. If so, child's age: _____ *Please describe:*

Issues with toilet training. If so, child's age: _____ *Please describe:*

Is your child currently toilet trained? Yes No

Has your child ever taken any medication and/or vitamins?

Medication/Vitamins	Started	Ended	Reason it was prescribed?	Did it work?

Please list the names of professionals currently involved in your child's care:

Name	Specialty	Address	Phone Number

Please list the names of professionals that have been involved in your child's care in the past:

Name	Specialty	Approximate Dates of Service

DEVELOPMENTAL INFORMATION

Infant-Toddler Period:

Were any of the following present—to a significant degree—during the first two years of life? Please check all that apply.

- Did not enjoy cuddling
- Was not calmed by being held and/or stroked
- Colic
- Excessive crying
- Sleeping problem
- Frequent head banging
- Constantly into everything
- Excessive number of accidents compared to other children
- Over-absorbed with sight, sound, smell or touch of things

Developmental Milestones:

List the age at which your child accomplished the following milestones, as best you can recall.

- | | |
|---|--|
| _____ Smiled | _____ Sat without support |
| _____ Crawled | _____ Walked alone |
| _____ Spoke in short sentences | _____ Rode tricycle |
| _____ Spoke first words (besides “mama” and “dada”) | _____ Bladder-trained, night |
| _____ Bladder-trained, day | _____ Tied shoelaces |
| _____ Bowel-trained, day | _____ Bowel-trained, night |
| _____ Buttoned clothing | _____ Drew a circle |
| _____ Named colors | _____ Rode bicycle (without training wheels) |
| _____ Said alphabet in order | _____ Began to read |

Has your child ever been exposed to extreme violence, abuse or neglect?

PAST SCHOOL INFORMATION
(Day Care, Pre-school, Kindergarten, Elementary School, High School)

Name of School	Years Attended	Grades	Services

Do you have any concerns about your child’s performance in the following academic areas:

- Reading Spelling Arithmetic Handwriting

Has your child ever repeated a grade? Yes No If yes, when? _____

Has your child’s school ever had any other concerns? If so, please describe:

Grade	Concern

Has your child ever had previous psychological or neuropsychological testing, either through school or privately? If so, please describe:

Doctor or School	Testing, Results, and Date of last testing