

CHILD AND FAMILY HISTORY FORM

Thank you for taking the time to complete this form. This information is essential for me to conduct a thorough evaluation of your child.

CHILD'S FULL NAME _____ Date of Birth _____

Completed by _____ on Date _____

Referred by _____

Contact Information

Parent /Guardian: _____

Address: _____

Phone: Home: _____ Cell: _____ Work: _____

Email: _____

Parent /Guardian: _____

Address (if different from above): _____

Phone: Home: _____ Cell: _____ Work: _____

Email: _____

Child's Primary Care Physician: _____

Name of Practice and Address: _____

_____ Phone: _____

Child's School: _____ District: _____

Teacher: _____ Grade: _____

General Information

	Please circle	Please circle
1.	<u>Mother/Father</u>	<u>Mother/Father</u>
Name	_____	_____
Education level	_____	_____
Occupation	_____	_____
Age	_____	_____
Religion	_____	_____

2. Are parents currently living together? Y N If not, describe custody arrangement:

3. Siblings:

Name	_____	M / F	Age_____	Full/Half/Adoptive/Step (circle)
Name	_____	M / F	Age_____	Full/Half/Adoptive/Step (circle)
Name	_____	M / F	Age_____	Full/Half/Adoptive/Step (circle)
Name	_____	M / F	Age_____	Full/Half/Adoptive/Step (circle)

Birth and Developmental History

Information requested pertains to the **biological** mother of the child.

1. Access to prenatal care? Yes _____ No _____

2. Use of medications during pregnancy?

<u>Name of medication</u>	<u>Reason taken</u>	<u>Trimester</u>
_____	_____	_____
_____	_____	_____

3. Any use of cigarettes, alcohol, or drugs during pregnancy?

<u>Substance</u>	<u>Amount used per week</u>	<u>Trimester</u>
_____	_____	_____
_____	_____	_____

4. Any medical problems during pregnancy? Please describe. _____

5. Length of pregnancy: _____ weeks Age of mother at birth: _____

6. Were there any problems with the delivery? Please describe: _____

Delivery was: Vaginal C-section Birth weight: _____

7. Were there any problems noted by anyone while the baby was still in the hospital? (e.g., jaundice, need for incubator/oxygen, feeding problems) _____

Did your child have any medical problems during infancy? _____

Feeding difficulties? _____

Colic? _____

Sleep difficulties? _____

8. How would you describe your child's temperament as an infant? Was he/she an "easy" baby? Was he/she cuddly? Difficult to soothe? _____

9. At what age did your child meet the following developmental milestones?
 (If exact ages are unknown, please indicate whether milestones were met on time or late or early.)

Smiling _____
 Rolling over _____
 Sitting _____
 Crawling _____
 Standing _____
 Walking _____
 Tolerating separation _____

AGE of first words (do not count "mama" or "dada") _____

AGE of first 2-3-word sentences _____

AGE your child was feeding self _____

AGE dressing self _____

AGE toilet trained during day _____

Medical History

1. Does your child have any chronic health problems (e.g. asthma, diabetes, heart disease)? _____

2. Has your child ever had any surgeries, major illnesses, or hospitalizations?

<u>Year</u>	<u>Procedure/Reason for Hospitalization</u>	<u>Outcome</u>
-------------	---	----------------

_____	_____	_____
_____	_____	_____

3. Has your child ever had a seizure or head injury? Please describe dates of incidents, any diagnostic testing performed (CT/MRI), and any medications given. Loss of consciousness?

4. Is your child taking any type of medication **currently**?

<u>Name of medication</u>	<u>Dosage</u>	<u>Reason</u>	<u>Date begun</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Has your child ever taken any medications **in the past**?

<u>Name of medication</u>	<u>Dosage</u>	<u>Reason</u>	<u>Dates</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. Date of most recent vision screen. Date: _____ Result: _____

Date of most recent hearing screen. Date: _____ Result: _____

7. Is your child on a special diet? Please describe: _____

Mental Health History

1. Please list any **Evaluations** your child has had (speech/language, developmental, psychology, neurology, occupational therapy (OT), etc.) **Please bring copies of these that I can keep to your first appointment.**

<u>Type</u>	<u>By Whom</u>	<u>Year</u>	<u>Diagnoses given</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. **Current and Past Therapies**

Please list current and past therapies (e.g., speech, occupational therapy, counseling) your child is receiving/has received with provider name:

<u>Therapy Type</u>	<u>Provider</u>	<u>Date Begun</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

School History

Current School: _____

Current Grade: _____

Do any of the following apply to your child's education history?

- IEP/504 plan
- Held back 1 or more grades
- Skipped 1 or more grades
- Learning problems
- Oppositional behavior
- Attention problems
- Hyperactivity problems
- Underachieving
- Difficulties with schoolwork/homework
- Other: _____

Are you happy with your child's current school/school team? If not, please explain:

Family History

Do any of your child's **biological** relatives have any of the following conditions? Please check all that apply, past or present.

	MOTHER	FATHER	MOTHER'S FAMILY	FATHER'S FAMILY	CHILD'S SIBLINGS
Intellectual Disability (i.e., MR)					
Autism					
Epilepsy					
Learning problems					
Attention problems					
Hyperactivity					
Impulsivity					
Anxiety					
OCD					
Depression					
Suicide Attempt					
Bipolar Disorder					
Alcohol Abuse					
Drug Abuse					
Schizophrenia					
Psychosis					
Criminal history					

Summary

Please briefly describe current **concerns** and **goals** you have for this evaluation/therapy: _____

Please briefly describe your child's **strengths**: _____
