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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 _____

PRONOUNS for Child: ❑she/her ❑he/him ❑they/them

GENDER of Child: ❑ Male ❑ Female ❑ Transgender Female ❑ Transgender Male
❑ Non-Binary ❑ Genderqueer

Completed by_____on Date _____

Referred by _____

Contact Information

Parent /Guardian #1: _____

Address: _____City: _____State: _____

Phone: Home:_____Cell:_____Work:_____

Email: _____

Parent /Guardian #2: _____

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 Family Information

	Please circle Mother/Father	Please circle Mother/Father
1. 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? Y N

2. Use of medications during pregnancy?

Name of medication	Reason taken	Trimester
_____	_____	_____
_____	_____	_____

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

Substance	Amount used per week	Trimester
_____	_____	_____
_____	_____	_____

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) _____
_____
_____

8. Did your child have any medical problems during infancy? _____
Feeding difficulties? _____
Sleep difficulties? _____
Colic?_____

9. How would you describe your child's temperament as an infant? Were they an "easy" baby? Cuddly? Difficult to soothe? Other? _____
_____
_____
_____

10. At ***what age*** did your child meet the following developmental milestones?
(If exact ages are unknown, please indicate whether milestones were met on time, 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 when your child was first feeding self. _____
AGE when your child was first 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. Does your child have any allergies? _____

3. Is your child up to date on vaccinations? _____

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

Year	Procedure/Reason for Hospitalization	Outcome
_____	_____	_____
_____	_____	_____

5. 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?

_____

_____

_____

6. Is your child taking any type of medication **CURRENTLY**?

Name of medication	Dosage	Reason	Date begun

7. Has your child ever taken any medications **IN THE PAST**?

Name of medication	Dosage	Reason	Dates

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

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

9. Is your child on a special diet? _____

Mental Health History

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

Type	By Whom	Year	Diagnoses given

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:

Therapy Type	Provider	Date Begun

School History

Current Grade: _____

Name of Preschool: _____

Elementary School: _____

Middle School: _____

High School: _____

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.

	BIO MOTHER	BIO 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:

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