CHILD/ADOLESCENT HISTORY/INFORMATION FORM

Name of Child_____Age____Date of Birth_____

Child's Primary Address:_____

City/State:_____Zip Code_____

School_____School Phone_____

Teacher's Name_____Grade_____

Physician's Name_____Phone_____

Mother's Name_____Age_____Education_____

Occupation:_____Employer:_____

Home Phone:_____ Work/Cell: _____

Email: _____

Father's Name_____Age_____Education_____

Occupation:_____Employer:_____

Home Phone:_____ Work/Cell: _____

Email: _____

Marital Status: ___Single___Married___Separated___Divorced
If applicable, date of Marriage: _____ Separation: _____ Divorce: _____

If divorced/separated, please describe child's visitation schedule:

_____

Who referred this child here? _____

I. Current Symptoms:

Describe the specific concerns that you have about your child today:

_____

_____

When did you first notice these problems? _____

Does your child have any of the following behaviors?
Please check all that apply.

_____ Poor eye contact
_____ Social withdrawal
_____ Temper tantrums
_____ Hand flapping
_____ Head banging
_____ Self-biting
_____ Skin picking or hair pulling (circle which)
_____ Aggression
_____ Household property destruction
_____ Public property destruction
_____ Excessive friendliness toward strangers
_____ Sensitivity to sound
_____ Sensitivity to touch
_____ Sensitivity to taste
_____ High pain tolerance
_____ Dislike of crowds
_____ Rigid, inflexible routines
_____ Speaks like an adult
_____ Speaks in a flat, monotone voice
_____ Speaks with a sing-song voice
_____ Preoccupations or obsessions
_____ Hoarding behavior (keeps things of no value such as paper cups, scraps of paper)
_____ Looks at objects in a strange way
_____ Rocks back and forth ___ full body ___ torso only
_____ Toe walking
_____ Poor balance/coordination
_____ Poor fine motor skills/difficulty with writing tasks
_____ Difficulty falling asleep
_____ Mid-night awakening
_____ Early morning awakening
_____ Difficulty awakening
_____ Snoring
_____ Throat-clearing during sleep
_____ Repetitive behaviors/acts
_____ Overactivity
_____ Inattention, difficult to direct their attention
_____ Lethargy (constant tiredness)
_____ Sexual acting out
_____ Lack of interest in previously enjoyed activities
_____ Excessive sadness, negative self talk, feelings of worthlessness (Nobody likes me; I'm a terrible person
_____ Mood swings
_____ Irritability
_____ Tics (frequent involuntary movements or vocalizations, such as eye blinking, facial twitching, throat clearing while awake)

Other symptoms not noted above: _____
_____

II. Birth History

A. Was this child adopted? **Y** **N** If yes, at what age_____

B. Birth History for this child

Born at _____ weeks gestation Induced? (circle) **Y** **N**
Birth weight? _____ Length of labor in hours _____
C-Section? (circle) **Y** **N** Length of Hospital Stay: _____
Prenatal care? **Y** **N** Other: _____

What drugs/medications were taken during pregnancy (include vaccinations)?_____
_____

During pregnancy or delivery, were there problems with any of the following? (Please circle.)

Mother:		Child:
Vaginal bleeding	Excessive vomiting	Jaundice (requiring lights)
Excessive weight gain	Hypertension	Meconium
Weight loss	Gestational diabetes	Cord wrapped around neck
Fevers	Proteinuria	Forceps used
Rashes	General infections	Anoxia at birth (respirator)
Fetal distress	Urinary tract infections	Prematurity
Preeclampsia	Viral infection (flu, etc.)	

If there were other problems not listed above, please describe:

_____

_____

Comments about child's appearance & behavior as newborn:

_____

Describe baby in first year (check all that apply):

Active____Passive____ | Content____Fretful____

Colic?_____ How long?_____ Digestive problems? _____

Difficulty establishing sleep patterns?_____ Feeding problems? _____

Medications prescribed first year_____

B. Developmental History (approx. ages in months):

Sat unsupported_____ Crawled or crept_____
Stood alone_____ Walked unattended_____
Single words_____ Short sentences_____
Toilet trained day _____Toilet trained night _____

C. Medical History

Has your child experienced any of the following? (Please circle.)

Headaches	Ear Infection (#_____)	Heart condition	Enuresis
Seizures	Ear Tubes	Cancer	Encopresis
Head injury	Hearing problems	Thyroid disease	Broken bones
Meningitis	Vision problems	Diabetes	HIV/AIDS
Lead poisoning	Asthma	Obesity	Toothaches
Lyme disease	Tuberculosis	Insomnia	Constipation
PANDAS	Chickenpox	Hypersomnia	Feeding problems
Surgery? (circle)	Adenoidectomy	Tonsillectomy	Appendectomy
	Other?_____		

Allergies? ___ Yes ___ No; if yes, describe: _____

Has your child experienced any medical condition that is not listed above? If so, please describe: _____

_____

Describe any serious accidents (falls, burns, broken bones, etc.)

_____

Age(s) at time of accident(s):_____

This child was last seen by Dr.:_____

Date_____ Findings:_____

Is child taking any medications? Please list:_____

_____

_____

Has your child ever been hospitalized? How long?_____at what age?_____ Explain: _____
_____

Date of last hearing screen _____Findings_____
Date of last vision screen _____ Findings_____

D. Previous Evaluations/Services

Has your child ever received a psychological/developmental evaluation?
If yes, when _____and by whom?_____
Outcome: _____

Has your child ever seen a mental health profession (psychologist, psychiatrist, counselor?) **Y N If yes, when, why, and what was the outcome?**

_____

_____

Has your child ever taken medication for behavioral/emotional issues?
Y N If yes, please list (to the best of your knowledge) the medications prescribed and the outcome: _____
_____
_____

Has your child ever had any of the following services? (Please circle and *indicate the time period when services were rendered.*)

Service			Dates of Service
Speech	Yes	No	From _____ to _____
Occupational therapy	Yes	No	From _____ to _____
Physical therapy	Yes	No	From _____ to _____
Special Education	Yes	No	From _____ to _____
PPCD	Yes	No	From _____ to _____
ECI	Yes	No	From _____ to _____
504 Accommodation	Yes	No	From _____ to _____
ABA	Yes	No	From _____ to _____

E. Family history

Please note a history of any of the following (include child's cousins, aunts, uncles, grandparents, as well as immediate family and indicate whether maternal or paternal family):

Illness	Relationship to child
Depression	_____
Suicide	_____
Bipolar Disorder	_____
Schizophrenia	_____
Psychiatric Hospitalization	_____
Delayed language	_____
Autism/PDD	_____
Dyslexia	_____
Other Learning Disability	_____
Mental Retardation	_____
ADHD	_____
Explosive temper	_____
Anxiety	_____
Obsessive Compulsive Disorder	_____
Tic/Tourette's Disorder	_____
Seizures/epilepsy	_____
Alcoholism	_____
Drug Addiction	_____
Criminal record	_____
Other (Explain)	_____

Who, in the extended family, is most like your child?
_____ Why? _____
_____

F. School history

Has your child ever repeated a grade? If yes, which one and for what reason?_____
_____

Has your child ever failed state-administered achievement tests? ____
If yes, please explain: _____

Please list the schools your child has attended and the city where attended, *beginning with daycare.*

School/City	Grade	How did your child do?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other:
Did your child have trouble learning...

phonics?_____ multiplication tables? _____

other (describe) _____
Latest report card grades: Language_____ Spelling_____
Reading_____ Science_____
Social studies_____ Math_____
Current school work: Is it done easily_____ or with difficulty_____
Does school work cause pressure at home?_____
Child needs help with_____

Does your child like school?_____
What does the teacher think the problem is
_____
_____

G. What languages are currently or have ever been spoken in the home?
_____

If more than one, which do you feel is your child's primary language?
_____

H. List by name all the people currently living in the home with this child, in order by age *beginning with the oldest*:

Name/ Relationship to child	Age	Highest year Of school completed or degree received	Any grade repeated	Did he/she ever have a learning problem?

How many times has your child changed residences (moved)? _____

Within the past 2 years, have there been any major life changes, such as deaths in the family, loss of a family pet, or changes of residence?_____
If yes, please describe:_____
_____

I understand that precautions to protect my child's identity will be taken in email communication, but that email is not a confidential means of conveying information. **I grant _____ do not grant _____ permission for email communication concerning my child.**

As this is a teaching facility, trainees may participate in your child's care. All diagnostic and treatment decisions will be made by your child's primary clinician. Your signature indicates your understanding of this. Please speak to your child's clinician if you have any questions.

_____ _____

Signature of parent/guardian Date

Please let us know of any important information that you would like us to know that we did not ask: