# HISTORY FORM

**Date:** _____/_____/_____
Month Day Year

**Child's Name:** _____
Last First Middle

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

**Address:** _____

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

**Phone #:** _____ **Email address:** _____
(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 father only
❑ natural mother and stepfather ❑ natural father and stepmother
❑ adoptive parents ❑ foster parents
❑ relatives: please specify _____
❑ institution: please specify _____

**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.

| Condition | Relationship to Child |
|---|---|
| ❑ Seizures, convulsions, epilepsy | |
| ❑ Cerebral palsy | |
| ❑ Cancer | |
| ❑ Muscular weakness | |
| ❑ Poor coordination, clumsy | |
| ❑ Slow motor development | |
| ❑ Deformities | |
| ❑ Early deaths | |
| ❑ Severe visual impairment | |
| ❑ Hearing loss | |
| ❑ Speech problems or late talker | |
| ❑ Traumatic Brain Injury | |
| ❑ Mental retardation | |
| ❑ Slow development | |

| Condition | Relationship to Child |
|---|---|
| ❑ Brain damage | |
| ❑ School difficulties | |
| ❑ Reading difficulty | |
| ❑ Learning disabilities | |
| ❑ Emotional/behavioral problems | |
| ❑ Attention deficit disorder | |
| ❑ Autism, PDD, Asperger's | |
| ❑ Psychiatric disorder | |
| ❑ Odd social/eccentric personality | |
| ❑ Tics or sudden unplanned movements | |
| ❑ Tourette's Syndrome | |
| ❑ Neurofibromatosis | |
| ❑ Tuberous sclerosis | |
| ❑ Fragile X | |
| ❑ Diabetes | |
| ❑ Immune system problems (rhumatoid arthritus, lupus, etc.) | |
| ❑ Thyroid disease | |
| ❑ Kidney disease | |
| ❑ Heart disease | |
| ❑ Heavy drinking | |
| ❑ 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
❑ Hospitalization required before due date
❑ Spotting or bleeding
❑ Accidents
❑ Anemia
❑ Toxemia
❑ Smoked during pregnancy; # of cigarettes per day: _____

❑ 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 ❑ Breech ❑ Forceps ❑ Cord around neck
❑ Multiple births: ❑ Twins ❑ Triplets ❑ 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 |
|---|---|
| | |
| | |
| | |