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Childhood History Form

Child's Name: _____ D.O.B.: _____
Age: _____ Sex: _____
Home Address: _____
_____ Home Phone: _____
Child's School: _____
Grade: _____ Special Placement (if any): _____
Parents: ❑ Never married ❑Married ❑Divorced (age of child at divorce _____)
Child: ❑ Adopted (age of child at adoption _____)
Child is presently living with:

❑Natural Mother ❑Natural Father ❑Stepmother ❑Stepfather
❑Adoptive Mother ❑Adoptive Father ❑Foster Father ❑Foster Father
❑Other (specify)

Non-residential adults involved with this child on a regular basis:
_____
_____
Source of Referral: Name _____
Address: _____ Phone: _____
Briefly state main problems of this child: _____
_____
_____
_____
_____

PARENTS

Mother: _____
Occupation: _____ Bus. Phone: _____
Age: _____ Age at time of pregnancy with patient (child): _____
Highest grade completed: _____
History of learning problems: _____
Attention problems: _____
Behavior problems: _____
Emotional/psychiatric problems: _____
Medical problems: _____

Prescriptions used for past/present psychiatric/psychological problems: _____
Have any of your blood relatives experienced any emotional or behavioral problems? If so, describe: _____
_____
Father: _____ Age: _____
Occupation: _____ Bus. Phone: _____
Highest grade completed: _____
History of learning problems: _____
Attention problems: _____
Behavior problems: _____
Emotional/psychiatric problems: _____
Medical problems: _____
Prescriptions used for past/present psychiatric/psychological problems: _____
Have any of your blood relatives experienced any emotional or behavioral problems? If so, describe: _____
_____

SIBLINGS

Name	Age	Medical, Social, Emotional or School Problems
1)		
2)		
3)		
4)		
5)		
6)		

Any family changes/stressors (relocation, separation, etc.) _____

PREGNANCY – Complications

Excessive vomiting: _____ Hospitalization required: _____
Excessive staining/blood loss: _____ Threatened miscarriage: _____
Infection(s) (specify): _____
Toxemia: _____ Infection(s) (specify): _____
Other illness(es) (specify): _____
Smoking during pregnancy: _____ # cigarettes per day: _____
Alcoholic consumption during pregnancy: _____
Describe if beyond an occasional drink: _____
Medications taken during pregnancy: _____
X-ray studies during pregnancy: _____
Duration of pregnancy (weeks): _____

DELIVERY

Type of labor: ❑Spontaneous ❑Induced Duration (hrs): _____

Type of delivery: ❑Normal ❑Breach ❑Caesarean

Complications: ❑Cord around neck ❑Hemorrhage ❑Infant injured during delivery

❑Other: _____

Birth Weight: _____

POST DELIVERY PERIOD

Jaundice: _____ Cyanosis (turned blue): _____ Incubator Care: _____

Infection (specify): _____

Number of days infant was in the hospital after delivery: _____

INFANCY PERIOD

Were any of the following present- to a significant degree during the first few years of life? If so, describe:

Did not enjoy cuddling: _____

Was not calmed by being held or stroked: _____

Difficult to comfort: _____

Colic: _____ Excessive restlessness: _____

Excessive irritability: _____

Diminished sleep: _____

Frequent head banging: _____

Difficult nursing/feeding: _____

Constantly into everything: _____

TEMPERAMENT

Please rate the following as your child appeared during infancy and toddlerhood

Activity Level – How active has your child been from and early age? _____

_____

Distractibility – How easily was your child's attention diverted? _____

_____

Adaptability – How well did your child deal with transition and change? _____

_____

Approach/Withdrawal – How well did your child respond to new things (i.e. places, people, food, routines, etc)?

_____

Intensity – Whether happy or unhappy, how aware are others of your child's feelings? _____

_____

Mood – What was your child's basic mood? _____

_____

Regularity – How predictable was your child in patterns of sleep, appetite, etc? _____

_____

Persistence and Attention – How well was your child able to persist in attaining a goal and to attend to one activity for a period of time? _____

_____

Sensory Threshold – Was your child over or under sensitive to light, sound, textures? _____

_____

MEDICAL HISTORY

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

Childhood diseases (describe ages and any complications): _____

_____

Operations: _____

Hospitalization for illness: _____

_____

Head injuries: _____

Convulsions: _____ with fever _____ without fever _____

Persistent high fevers: _____

Eye problems: _____

Tics (i.e. eye, blinking, sniffling, any repetitive, non-purposeful movements: _____

_____

Ear problems: _____

Allergies or Asthma: _____

Poisoning: _____

Sleep

Does your child settle down to sleep? _____

Sleep through the night without disruption? _____

Experience nightmares, night terrors, sleep walking, sleep talking? _____

Is your child a restless sleeper? _____

Does your child snore? _____

Any recent changes in sleep patterns within the past 6 months? _____

Appetite: _____

Any recent changes in appetite within the past 6 months? _____

Past medications for Psychological/Behavioral Problems:

Date	Prescription	Dose	Response	Physician
1)				
2)				
3)				
4)				

PRESENT MEDICAL STATUS

Height: _____ Weight: _____

Present illnesses for which the child is being treated: _____

_____

Medications child is taking on an ongoing basis: _____

_____

Has your child been exposed to physical/emotional/sexual abuse? _____

Please explain: _____

DEVELOPMENTAL MILESTONES

If you can recall, record the age at which your child reached the following developmental milestones. If you cannot exactly recall, check item at right.

	Age	Early	Normal	Late
Smiled:				
Sat without support:				
Crawled:				
Stood without support:				
Walked without assistance:				
Spoke first words:				
Said phrases:				
Said sentences:				
Bladder trained, day:				
Bladder trained, night:				
Bowel trained, day:				
Bowel trained, night:				
Rode tricycle:				
Rode bicycle (without training wheels):				
Buttoned clothing:				
Tied shoelaces:				
Named colors:				
Tell time:				
Named coins:				
Said Alphabet in order:				
Began to read:				

COORDINATION

Walking: _____
Running: _____
Throwing: _____
Catching: _____
Shoelace trying: _____
Buttoning: _____
Writing: _____
Athletic abilities: _____
Excessive number of accidents compared to other children: _____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his or her age? If not, why not? _____

_____

_____

How would you rate your child's overall level of intelligence compared to other children?
Below Average _____ Average _____ Above Average _____

SCHOOL HISTORY

Were you concerned about your child's ability to succeed in kindergarten? If so, please explain:

_____

_____

Rate your child's School Experience related to *academic learning*: **Good** **Average** **Poor**
Nursery School: _____
Kindergarten: _____
Current grade: _____
To the best of your knowledge, at what grade level is your child functioning:
Reading_____ Spelling_____ Arithmetic_____
Has your child ever had to repeat a grade? If so, when? _____
Has your child been formally evaluated for learning problems or a gifted and talented program? _____
Present class placement: Regular class_____ Special class (specify)_____

_____

Kinds of special counseling or remedial work your child is currently receiving: _____

_____

Describe briefly any academic school problems: _____

_____

_____

_____

_____

Rate your child's School Experience related to *behavior*: **Good** **Average** **Poor**

Nursery School: _____

Kindergarten: _____

Current grade: _____

As best as you can recall, please use the following space to provide a general description of your child's school progress in each grade. Use the back of this form if extra space is needed.

_____

_____

_____

_____

Does your child's teacher report any of the following as significant classroom problems?

Doesn't sit still in his or her seat: _____

Frequently gets up and walks around the classroom: _____

Shouts out. Doesn't wait to be called on: _____

Doesn't wait his or her turn: _____

Doesn't cooperate well in group activities: _____

Typically does better in a one-to-one relationship: _____

Doesn't respect the rights of others: _____

Doesn't pay attention during storytelling or show and tell: _____

Describe briefly any other classroom behavioral problems: _____

_____

_____

_____

PEER RELATIONSHIPS

Does your child seek friendships with peers?

Is your child sought by peers for friendship?

Does your child play with children primarily his or her own age?

Younger? _____ Older? _____

Has your child's behavior caused him/her to be neglected by peers? _____

Describe briefly any problems your child may have with peers:_____

_____

_____

_____

_____