



CHILD HISTORY FORM

Child's Name _____ Date of Birth _____

Address _____

School _____ Grade _____

Phone number (home) _____ Phone number (cell) _____

Ethnicity _____

Parent's Information		Parent's Information	
Name		Name	
Occupation		Occupation	
Education		Education	

This is your Biological Adopted Foster child

Parents are Unmarried Married Separated Divorced Widowed/Widower

(Name of the child's legal guardian(s) if different from above): _____

Please list all children/adults who reside with the child.

Full Name	Sex	Date of Birth	Age	Grade	Relationship

Please list all other family members who do not reside with the child.

Full Name	Sex	Date of Birth	Age	Grade	Relationship

Reason(s) you are requesting services : _____

History of Treatment: Therapies/Evaluations

	Psychology/Psychiatry	Occupational Therapy	Physical Therapy	Speech/Language
<i>Treatment</i>				
Date(s)				
Provider				
<i>Evaluation</i>				
Date(s)				
Provider				

Does your child receive special services at school: no yes; 504 or IEP; Exceptionality _____

Current medical diagnoses: no yes _____

Current psychiatric diagnoses: no yes _____

Current speech diagnoses: no yes _____

Developmental History

1. Temperament: cuddly fussy social quiet difficult to soothe slow to adjust to change
2. Motor: Age Sat alone _____ Crawled _____ Walked alone _____
3. Language: Age Spoke first word _____ Put 2-words together _____ Put 3-words together _____
4. Toilet Training: Age training was initiated _____ Bowel _____ Bladder _____
 Age training was completed _____ Bowel _____ Bladder _____
5. Eating difficulties? no yes _____
6. Sleeping difficulties? no yes _____
7. Problems with separation from parent(s)? no yes _____
8. Behavior Problems? no yes _____

9. Did your child receive Birth-To-Three Services? no yes: OT PT Speech

Medical/Health

1. Physician Name: _____ Phone Number: _____
Address: _____

2. Is your pediatrician aware of this referral? no yes

3. Has vision been checked(date)? _____ any problems: _____

4. Has hearing been checked(date)? _____ any problems: _____

5. List all serious illnesses/injuries/hospitalizations/surgeries

Date	Incident (explain)
_____	_____
_____	_____
_____	_____
_____	_____

6. Medication Please list all current and past medications:

Type	Dose	Start Date	End Date

7. Provide full name of prescribing physician here _____ Phone Number _____

Education

1. Days absent in past year: _____

2. Skipped or repeated a grade: no yes _____

3. Teacher report problems in: reading spelling math writing behavior
attention/concentration social adjustment

4. **Grade:** **Academic Problems? (please explain)**

Nursery	_____
Kindergarten	_____
First	_____
Second	_____
Third	_____
Fourth	_____
Fifth	_____
Sixth	_____
Seventh	_____
Eighth	_____

Ninth _____
Tenth _____
Eleventh _____
Twelfth _____

Social

- no yes: My child plays with children his/her own age.
- no yes: My child engages in normal imaginative or pretend play.
- no yes: My child's play generally revolves around one particular theme with minimal variation.
- no yes: My child is willing to let others join in games and play situations.
- no yes: My child engages in parallel play (plays besides another but does not engage them).
- no yes: My child engages in cooperative play.
- no yes: My child gets along well with other children.

Behavior

Please mark any boxes that describe your child:

- | | | | | |
|--|---|---|--|-------------------------------------|
| <input type="checkbox"/> Poor eye contact | <input type="checkbox"/> Unusual vocal patterns | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Sensitive |
| <input type="checkbox"/> Sad | <input type="checkbox"/> Tense | <input type="checkbox"/> Disorganized | <input type="checkbox"/> Easily frustrated | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Temper tantrum | <input type="checkbox"/> Uses alcohol/drugs | <input type="checkbox"/> Nail biting | <input type="checkbox"/> Head bangs | <input type="checkbox"/> Happy |
| <input type="checkbox"/> Distractible | <input type="checkbox"/> Friendly | <input type="checkbox"/> Helpful | <input type="checkbox"/> Immature | <input type="checkbox"/> Unhappy |
| <input type="checkbox"/> Often Tearful | <input type="checkbox"/> Dependent | <input type="checkbox"/> Self-injurious behaviors | | |
| <input type="checkbox"/> Trouble with the police | | <input type="checkbox"/> Repetitive/stereotyped movements | | <input type="checkbox"/> Nightmares |

Signature

Signature

Relationship to child

Relationship to child

Date

Date