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CHILD HISTORY FORM

For Office Use Only: Interview held on	from	to	with

Instructions: Please answer all of the following questions to the best of your ability. Notes

Child's name: _____ Date: _____
Address: _____ Date of birth: _____ Age: _____
_____ Sex: ☐ Male ☐ Female ☐ Other
Home phone: _____ Work phone: _____
Cell phone/other phone: _____ Email: _____
Name of person completing form: _____ Relationship to child: _____
Child's primary care physician, address, and phone: _____
_____

Referral Information

Who referred you for an evaluation/psychological services? _____
What are you hoping to gain from these services? _____
_____
_____
In your opinion, what is the major cause of this child's difficulties? _____
_____
Describe some of this child's strengths: _____
_____
Describe some of this child's weaknesses: _____
_____
Do caregivers agree about the nature and causes of the problem? _____

Pregnancy and Birth History

Child is: ☐ biological ☐ adopted (at age _____) ☐ foster
Was this child a planned pregnancy? ☐ No ☐ Yes
Was the mother under a doctor's care? ☐ No ☐ Yes
Number of previous pregnancies: _____ miscarriages: _____

Check any of the following health complications during the pregnancy.

☐ Fertility problems	☐ Vaginal bleeding	☐ Toxemia
☐ High blood pressure	☐ Gestational diabetes	☐ Trauma
☐ Fever/rash (e.g., flu, measles)	☐ Emotional problems	☐ Abnormal weight gain
☐ Anemia	☐ Excessive swelling	☐ Excessive vomiting
☐ Blood incompatibility	☐ Smoking	☐ Alcohol
☐ Illicit drugs	☐ Medications	☐ Other: _____

☐ Hospitalization during pregnancy: Reason: _____
☐ X-rays during pregnancy: What month? _____
List any medications, tobacco use, alcohol use, or other drugs during pregnancy: _____
_____

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Age of mother: _____ and father: _____ at delivery Age of mother at birth of first child: _____
Birth weight: _____ lbs. _____ oz. Length of pregnancy: _____ weeks
Length of labor: _____ hours Apgar scores: _____
Delivery was: ☐ vaginal ☐ Cesarean (reason _____)

Check any of the following complications during birth.
☐ Breech birth ☐ Cord around neck ☐ Meconium staining
☐ Lacking oxygen ☐ Forceps used ☐ Labor induced
☐ Other: Describe: _____
☐ Jaundiced: Bilirubin lights? ☐ No ☐ Yes If yes, how long? _____
Did baby breathe spontaneously? ☐ No ☐ Yes Oxygen required? ☐ No ☐ Yes
Length of stay in hospital: Mother: _____ days Child: _____ days
Medical problems after discharge (e.g., jaundice, fever, transfusion, surgery)? _____
_____
Any problems in first few months? ☐ No ☐ Yes Explain: _____
Did mother experience postpartum (after birth) depression? ☐ No ☐ Yes
Describe this child's temperament as an infant: _____

Developmental History
Motor
Age sat alone: _____ crawled: _____ stood alone: _____ walked alone: _____
Was this child slow to develop motor skills or awkward compared to siblings/friends (e.g., running, skipping, climbing, playing ball, handwriting)? _____
Handedness: ☐ right ☐ left ☐ both (explain) _____
☐ History of physical therapy? When? _____
☐ History of occupational therapy? When? _____

Speech/Language
Age spoke first word: _____ put 2-3 words together: _____ spoke in sentences: _____
☐ Oral motor problems (e.g., late drooling, poor sucking, poor chewing)? Describe: _____
_____
☐ Speech delay/problems (e.g., stutters, difficult to understand)? _____
_____
☐ History of speech/language therapy? When? _____
Was this child slow to: ☐ learn alphabet? ☐ name colors? ☐ count?
☐ Other language spoken in home (besides English)? _____

Toileting
Age when toilet trained: _____
☐ Problems with bed wetting? Until what age? _____
☐ Urine accidents? Until what age? _____
☐ Soiling accidents? Until what age? _____
☐ Current wetting or soiling problems? Explain: _____

How old was this child when you first became concerned about his/her social/emotional/behavioral functioning? _____

Medical History

Check any that apply and indicate age.

☐ Failure to thrive	☐ Febrile seizures	☐ Epilepsy
☐ Staring spells	☐ Lead poisoning	☐ Toxic ingestion
☐ Meningitis	☐ Encephalitis	☐ Asthma
☐ Allergies	☐ Diabetes	☐ Loss of consciousness
☐ Stomach pain	☐ Vomiting	☐ Headaches
☐ Constipation	☐ Urination problems	☐ Accident prone
☐ Frequent ear infections	☐ Sleep problems	☐ Eating problems
☐ Tics/twitching	☐ Repetitive movements	☐ Impulsivity
☐ Temper tantrums	☐ Nail biting	☐ Clumsiness
☐ Head banging	☐ Self-injurious behavior	☐ Rocks back and forth

Has vision been checked? ☐ No ☐ Yes Any problems? _____

Has hearing been checked? ☐ No ☐ Yes Any problems? _____

History of ear tubes? ☐ No ☐ Yes

List serious illnesses/injuries/hospitalizations/surgeries.

Incident (explain)	Age
_____	_____
_____	_____
_____	_____

Check if any of the following have been performed (list dates).

☐ CT _____ ☐ MRI _____ ☐ EEG _____

List results of these or other tests: _____

Describe head injuries (e.g., date, type, loss of consciousness, associated symptoms): _____

_____

Current medications/supplements and reasons: _____

_____

Is there a family history of (list problems and relationships of family members):

learning or attention problems? _____

_____

psychiatric problems (e.g., depression, anxiety, schizophrenia, other mental illness)? _____

_____

alcoholism or substance abuse? _____

_____

autism spectrum disorder or intellectual disability? _____

_____

neurological illness (e.g., Alzheimer's disease, Huntington's chorea, Parkinson's disease, epilepsy)? __

_____

other medical illness (e.g., high blood pressure, cancer, diabetes, migraine headaches, heart disease)? __

_____

Does anyone else in the family have a problem similar to this child's reason for referral? _____
_____

Family Information

Parent/Caregiver name: _____ age: _____ education: _____
Occupation: _____ Employer: _____
Parent/Caregiver name: _____ age: _____ education: _____
Occupation: _____ Employer: _____
Parents are: ☐ married ☐ separated ☐ divorced ☐ never married
Describe the nature of the current relationship between the parents (e.g., loving, friendly, civil, conflictual, violatile): _____
Do the parents generally agree on child rearing strategies (e.g., discipline)? ☐ No ☐ Yes
Is this child closer to one parent than another? ☐ No ☐ Yes If yes, which? _____
If divorced, who has custody of this child? _____
Describe the visitation arrangements: _____

List all brothers and sisters, and any other members of the household(s).

Age	Sex	Name/relationship to this child	Living at home?	Problems?
_____	-	_____	_____	_____
_____	-	_____	_____	_____
_____	-	_____	_____	_____
_____	-	_____	_____	_____
_____	-	_____	_____	_____
_____	-	_____	_____	_____

Is this child in a child-care setting? ☐ No ☐ Yes How many hours/day? _____
Has this child ever experienced death or separation from a loved one? ☐ No ☐ Yes
Explain: _____

Social History

Does this child:

have difficulty relating to or playing with other children?	☐ No	☐ Yes
interact better with adults than children his/her own age?	☐ No	☐ Yes
have difficulty making/keeping friends?	☐ No	☐ Yes
understand gestures?	☐ No	☐ Yes
have a good sense of humor?	☐ No	☐ Yes
understand social cues well (e.g., knows when others are angry)?	☐ No	☐ Yes
have problems with peer pressure (e.g., alcohol or drug use)?	☐ No	☐ Yes
show a desire to please you?	☐ No	☐ Yes

Adaptive Functioning

Please list any chores or responsibilities this child has at home: _____
_____
Describe screen media use: _____

Psychological History

Please describe this child's typical mood: _____

List any previous direct contact with any social agency, psychologist, or psychiatrist.

Name and type of professional	Reason for services	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Academic History

Current school and address: _____

Grade: _____ Placement: ☐ regular ☐ resource ☐ special education ☐ other

Any grades that were skipped or repeated? ☐ No ☐ Yes Explain: _____

Check any of the following teachers have reported problems in.

☐ Reading
☐ Spelling
☐ Arithmetic
☐ Writing
☐ Attention/concentration
☐ Behavior
☐ Social adjustment

Describe any academic problems.

Preschool _____

Kindergarten _____

Early elementary school (1st to 2nd) _____

Upper elementary school (3rd to 5th) _____

Middle school (6th to 8th) _____

High school _____

Has this child been tested for special education? ☐ No ☐ Yes Results: _____

Does this child have an IEP? ☐ No ☐ Yes If so, describe services: _____

_____

Additional Comments

_____
_____
_____
_____
_____
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