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HISTORY QUESTIONNAIRE: CHILDREN / ADOLESCENTS

Child's Name _____ Today's date _____ Date of birth _____ Age _____

Child's Address _____

Sex: ☐ Male ☐ Female Grade _____ Primary Language _____ Secondary language _____

Form Completed By: _____

If parents are separated or divorced, who has custody? _____

If applicable, how often does the child see his/her non-custodial parent? _____

Please list all current medications and dosages (include non-prescription drugs & supplements):

_____

Briefly describe why you are seeking help:

_____

_____

Are there any legal or court proceedings related to this child? ☐ Yes ☐ No If yes, please explain:

_____

PARENTS & PRIMARY CAREGIVERS

Mother's Name _____ Age _____ Education _____ Occupation _____

Primary Language _____ Secondary language _____ Knows about appointment □ Yes □ No □ Not sure

Address (if different from child) _____

Father's Name _____ Age _____ Education _____ Occupation _____

Primary Language _____ Secondary language _____ Knows about appointment: □ Yes □ No □ Not sure

Address (if different from child) _____

Step Parent Name _____ Age _____ Education _____ Occupation _____

Primary Language _____ Secondary language _____ Knows about appointment: □ Yes □ No □ Not sure

Address (if different from child) _____

Other Caregiver: _____ Relationship to child: _____

Knows about appointment: □ Yes □ No □ Not sure

FAMILY/HOUSEHOLD

What is this child's current living situation? _____

How long has he/she lived in this situation? _____

List all brothers and sisters, including any step- or half-siblings:

Name	Sex	Age	Relationship to Child	Living in same home?

List any others who live in the home, including relationship to the child: _____

Has child experienced any of the following? If "yes", indicate the age of the child at the time:

Parental separation?	□ Yes □ No	Age: _____
Parental divorce?	□ Yes □ No	Age: _____
Parental death?	□ Yes □ No	Age: _____
Death of sibling?	□ Yes □ No	Age: _____
Witnessed a traumatic event?	□ Yes □ No	Age: _____
Been the victom of a traumatic event or loss?	□ Yes □ No	Age: _____

DEVELOPMENTAL HISTORY - Pregnancy

During pregnancy, was the mother under a doctor's care? □ Yes □ No □ Don't know

Check any of the following that occurred during pregnancy with this child:

□ Difficulty conceiving	□ Excessive weight gain	□ Excessive vomiting	□ Anemia
□ Toxemia	□ German measles	□ Measles	□ Bleeding
□ Excessive swelling	□ Depression	□ High blood pressure	□ Influenza
□ Use of alcohol	□ Smoking	□ Exposure to X-rays	

□ Maternal injury: _____

□ Maternal hospitalization: _____

□ Rh factor: _____

□ Medications during pregnancy: _____

□ Street drugs during pregnancy: _____

DEVELOPMENTAL HISTORY - Birth

Length of pregnancy _____ (weeks) Length of labor _____ (hours) Age of mother at delivery _____

Check any of the following that occurred during or immediately following delivery:

□ Induced labor	□ Unplanned C-section	□ Planned C-section	□ Breech birth
□ Incubator _____ (days)	□ Jaundice	□ Use of oxygen	□ Other: _____

Additional information regarding pregnancy, delivery, or early weeks of life: _____

_____

DEVELOPMENTAL HISTORY - ADOPTION

Is your child adopted? □ Yes □ No If yes, what age? _____ □ Domestic □ International

What were the circumstances of your child's adoption? _____

_____

DEVELOPMENTAL HISTORY – Early Childhood

Indicate the age (months or years) at which this child first accomplished the following milestones:

Sat up alone	_____	Spoke first words	_____
Crawled	_____	Put two words together	_____
Walked alone	_____	Spoke in sentences	_____

Age potty-trained for urine: _____ For bowel movements: _____

Did/does child wet the bed? □ Yes □ No If yes, until what age? _____

Did/does soil the bed? □ Yes □ No If yes, until what age? _____

Check any of the following areas in which the child has/had significant difficulties and describe briefly:

□ Speech/Language: _____

□ Gross motor (e.g., walking, running): _____

□ Fine motor (e.g., buttons, scissors, holding a pencil): _____

□ Sensory: _____

□ Sleep: _____

□ Eating: _____

□ Temper tantrums: _____

□ Separation from parents: _____

□ Excessive crying: _____

□ Social Skills: _____

□ Other areas: _____

Did your child receive Birth to Three Services? □ Yes □ No

Which hand does this child use for the following activities?

Writing or drawing:	□ Right	□ Left	□ No preference (ambidextrous)
Holding a spoon to eat:	□ Right	□ Left	□ No preference (ambidextrous)
Throwing a ball:	□ Right	□ Left	□ No preference (ambidextrous)

MEDICAL HISTORY

Check all that apply and indicate age at the time of illness or injury:

□ Head injury <u>with</u> loss of consciousness Age: _____

□ Head injury <u>without</u> loss of consciousness Age: _____

□ Lyme disease Age: _____

□ Seizures Age: _____

□ Lead poisoning Age: _____

□ Meningitis Age: _____

□ Encephalitis Age: _____

□ Coma Age: _____

□ Sustained high fever Age: _____

□ Measles (rubeola) Age: _____

□ German measles (rubella) Age: _____

□ Chicken pox Age: _____

□ Whooping cough Age: _____

□ Mumps Age: _____

□ Broken bones Age: _____

□ Other major illness, injury, or surgery _____

Has your child had a hearing screening? □ Yes □ No Age:_____ Results:_____

Has your child had a vision screening? □ Yes □ No Age:_____ Results:_____

CURRENT MEDICAL PROBLEMS If "Yes", give brief description or explanation:

Allergy to medication	□ Yes □ No	_____
Allergy to food	□ Yes □ No	_____
Seasonal allergies	□ Yes □ No	_____
Frequent colds	□ Yes □ No	_____
Frequent ear aches	□ Yes □ No	_____
Frequent stomach aches	□ Yes □ No	_____
Excessive vomiting	□ Yes □ No	_____
Intestinal problem	□ Yes □ No	_____
Bladder control	□ Yes □ No	_____
Bowel control	□ Yes □ No	_____
Asthma	□ Yes □ No	_____
Heart condition	□ Yes □ No	_____
Scoliosis	□ Yes □ No	_____
Other current medical	□ Yes □ No	_____

SOCIAL & BEHAVIORAL CONCERNS

Fights frequently with peers	□ Yes □ No
Has difficulty making friends	□ Yes □ No
Prefers to play with younger children	□ Yes □ No
Prefers to play with older children	□ Yes □ No
Prefers to play alone	□ Yes □ No
Easily over-stimulated in play	□ Yes □ No
Overly energetic in play	□ Yes □ No
Overreacts when faced with problems	□ Yes □ No
Unhappy or sad much of the time	□ Yes □ No
Irritable or easily angered much of the time	□ Yes □ No
Lacks self-control; impulsive	□ Yes □ No
Smokes cigarettes or chews tobacco	□ Yes □ No
Inhales toxic substances (e.g., paint)	□ Yes □ No
Uses illegal drugs	□ Yes □ No
Drinks alcohol	□ Yes □ No

Role in peer group activities ("leader", "follower", "just watches", etc.): _____

INTERESTS, HOBBIES, SPORTS

List child's interests and activities: _____

Has there been a change or decline in activities recently? □ Yes □ No Describe: _____

EDUCATION/ACADEMICS

Current school: _____

List all schools attended and give reason for any changes other than normal progression:

_____

_____

_____

_____

_____

Pre-school or daycare? □ Yes □ No Describe any problems: _____

Kindergarten? □ Yes □ No Describe any problems: _____

Ever repeat a grade? □ Yes □ No Details: _____

Ever skip a grade? □ Yes □ No Details: _____

Problem learning to read? □ Yes □ No Describe: _____

Current reading problem? □ Yes □ No Describe: _____

Difficulty with math? □ Yes □ No Describe: _____

Placed in Special Ed? □ Yes □ No Details: _____

Placed in gifted classes? □ Yes □ No Details: _____

Frequent absences? □ Yes □ No Details: _____

Frequent tardiness? □ Yes □ No Details: _____

Behavior problems? □ Yes □ No Details: _____

Tutoring? □ Yes □ No Details: _____

Speech therapy? □ Yes □ No Details: _____

Problems with homework? □ Yes □ No Describe: _____

Grades in elementary school: □ Mostly A's □ A/B □ B/C □ C/D □ Other: _____

Grades in middle school: □ Mostly A's □ A/B □ B/C □ C/D □ Other: _____

Grades in high school: □ Mostly A's □ A/B □ B/C □ C/D □ Other: _____

If in high school now, when will he/she graduate? _____

What do you consider this child's greatest strengths and talents? _____

_____

FAMILY MEDICAL & PSYCHIATRIC HISTORY: Provide information on <u>blood</u> relatives only.

	Age	OR	Age at Death	<u>Medical</u> and <u>Psychiatric</u> History (including alcohol/drugs)
Father	_____		_____	_____
Mother	_____		_____	_____
Brothers	_____		_____	_____
	_____		_____	_____
	_____		_____	_____
Sisters	_____		_____	_____
	_____		_____	_____
	_____		_____	_____

MENTAL HEALTH HISTORY

Has your child had a previous developmental or psychological assessment? □ Yes □ No

Please describe: _____

Has your child ever received services from a mental health professional? □ Yes □ No
(e.g.: psychologist, social worker, counselor, therapist, psychiatrist)

If yes, please describe (include dates and types of treatment):

_____

_____

_____

_____

_____

Has your child ever been hospitalized for psychiatric treatment? □ Yes □ No

If yes, please describe (include dates of hospitalization):

_____

_____

_____

_____

_____

Has your child ever experienced a separation, loss, or traumatic event? □ Yes □ No

If yes, please describe:

_____

_____

_____

_____

_____

ADDITIONAL INFORMATION

If there is any other information that you think is important for us to know, please write it below:

_____

_____

_____

_____

_____

Name of person who completed this form: _____

Relationship to child: _____