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CHILD HISTORY QUESTIONNAIRE

Today's Date: _________________

Parent Information:

Name ________________________________

Home Address ____

City/State/Zip____

Home Phone ___________________________

Work Phone ________________________

Drivers License # _______________________

Date of Birth ___________________________

Social Security Number __________________

Employer ______________________________

Work Address ____

City/State/Zip ____

Work Phone ____

Name of Spouse/Partner ____

Names of Legal/Custodial Parent/s____

Child Information

Name ____

Date of Birth ____/____/_______

Address____

Street *Apt.*

____

City *State* *Zip*

Mother's Name ___________________________ Age ____ Occupation _________________

Father's Name ____________________________ Age ____ Occupation ________________

Home Telephone___________________ Work/Day Phone_____________________

Child's Legal Guardian(s)____

In case of an emergency, please contact:

Name: __________________________ Relationship to Child: _________________

Tel #: ____

Referred by: _______________________________Relation to child ______________________

Referrer's Address ____

If referred by self, how did you obtain Dr. Maker's name and number? _____________________

____

Reason for Referral ____

Primary Care Physician's Name____

Address____

Date of Last Physical____

Please list any current medical concerns ____

Please list any medications child is taking, including dosages and frequency_________________

____

Please list members of child's immediate family and other members of household____________

Parental Status

If partnered, for how long: ______________ If married, on what date: _______________

> If separated or divorced, please give date(s) and on the back of this page explain the circumstances, custody & visitation schedule (if any) and communication status between parents. Additionally, please attach a copy of the custody order.

If a parent is deceased, please give the date and explain the circumstances:

Developmental History

If adopted, please give any relevant information about biological parent history:

Briefly describe your child:

(If adopted, please answer to the best of your knowledge).

Were there any illnesses/complications during pregnancy with this child?

Total number of pregnancies: __________

Were there any miscarriages: __________ Please explain circumstance(s):

Pregnancy was (circle one) Full Term Premature Late

If premature or late, number of weeks _________

Labor was (circle one) Less than 2 hours More than 24 hours 2 to 24 hours

Delivery was (circle one)
Normal Induced Breech Cesarean Section

Birth Weight _________________

During pregnancy, did any of the following occur? If yes, please add additional detail, including when in pregnancy, frequency, names of medications, etc.

Bleeding	Yes	No	____________________________
High Blood Pressure	Yes	No	____________________________
Frequent Nausea or Vomiting	Yes	No	____________________________
Serious Illness or Injury	Yes	No	____________________________
Gestational Diabetes	Yes	No	____________________________
Use Alcohol	Yes	No	____________________________
Smoke Cigarettes	Yes	No	____________________________
Take Prescription Medications	Yes	No	____________________________
Use Drugs	Yes	No	___________________________

During delivery, did any of the following occur? If so, please specify

Fetal cardiopulminary distress	Yes	No	____________________________
Cord wrapped around neck	Yes	No	____________________________
Need for oxygen	Yes	No	____________________________
Had difficulty breathing	Yes	No	____________________________
Infection	Yes	No	____________________________
Injury	Yes	No	____________________________
Early distress or birth defect	Yes	No	____________________________
Did baby leave hospital with mother?	Yes	No	____________________________

Is there anything else of note regarding pregnancy or delivery? ___________________________

Early Development

During the first year, was your child: Please describe:

Alert	Yes	No	______________________________
Difficult to feed	Yes	No	______________________________
Difficult to get to sleep	Yes	No	______________________________
Difficult to put on a schedule	Yes	No	______________________________
Colicky	Yes	No	______________________________
Easy to soothe	Yes	No	______________________________
Cheerful	Yes	No	______________________________
Affectionate	Yes	No	______________________________
Sociable	Yes	No	______________________________
Active	Yes	No	______________________________

Was there anything else notable about your child in the first years?_________________________

____

____

When did your child reach the following milestones:

Smiling	Early	Average	Late	_______________________________
Sitting	Early	Average	Late	_______________________________
Crawling	Early	Average	Late	_______________________________
Walking	Early	Average	Late	_______________________________
First words	Early	Average	Late	_______________________________
First sentences	Early	Average	Late	_______________________________
Toilet trained	Early	Average	Late	_______________________________
Ride a bicycle	Early	Average	Late	_______________________________
Drawing	Early	Average	Late	_______________________________

Were there any other early milestones of note, either early or late? _________________________

____

____

Medical History

Is child in generally good health? __________ If no, please describe________________________

____

Does your child have any current medical or genetic condition? If so, please describe

____

____

Does your child have, or has your child ever had, any of the following? If so, please specify.

Vision problems	Never	Past	Current	______________________________
Hearing problems	Never	Past	Current	______________________________
Frequent ear infections	Never	Past	Current	______________________________
Head injury	Never	Past	Current	______________________________
High fevers	Never	Past	Current	______________________________
Broken bones	Never	Past	Current	______________________________
Lead Poisoning	Never	Past	Current	______________________________
Seizures	Never	Past	Current	______________________________
Allergies	Never	Past	Current	______________________________
Asthma	Never	Past	Current	______________________________
Frequent headaches	Never	Past	Current	______________________________
Hospitalizations	Never	Past	Current	______________________________
Frequent falls or clumsiness	Never	Past	Current	______________________________
Frequent bruising	Never	Past	Current	______________________________
Heart or breathing difficulty	Never	Past	Current	______________________________

Surgery	Never	Past	Current
			______________________________
Other serious illness or injury	Never	Past	Current
			______________________________

Is your child currently under the care of a physician other than a pediatrician?

____

Has your child ever been referred to a medical specialist? If so, what specialty and why? ______

____

Please note any other health concerns, past or current. ___________________________________

____

____

Has your child ever had strong reactions to any of the following?

Tags on clothes, or seams on socks	Yes	No ______________________________
New clothing	Yes	No ______________________________
Tight clothing	Yes	No ______________________________
Hugging	Yes	No ______________________________
Touch	Yes	No ______________________________
Noises or sounds	Yes	No ______________________________
Smells	Yes	No ______________________________
Tastes or food textures	Yes	No ______________________________
Bright lights	Yes	No _____________________________

How well does your child manage transitions from one activity to another? _________________

____

How does your child react to changes in schedule or new situations? _____________________

____

____

Do you have any concerns or comments about your child's social interactions with peers? _____

____

____

____

Family History

Does anyone in the immediate or extended family have any of the following? If so, please explain:

Attention problems	Parent	Sibling	Extended Family_________________
Learning problems	Parent	Sibling	Extended Family_________________
Difficulty reading	Parent	Sibling	Extended Family_________________
Difficulty with math	Parent	Sibling	Extended Family_________________
Difficulty writing	Parent	Sibling	Extended Family_________________
Seizure Disorder	Parent	Sibling	Extended Family_________________
Depression	Parent	Sibling	Extended Family_________________
Anxiety	Parent	Sibling	Extended Family_________________
Bipolar Disorder	Parent	Sibling	Extended Family_________________
Obsessive Compulsive Disorder	Parent	Sibling	Extended Family_________________
Other psychiatric disorder	Parent	Sibling	Extended Family_________________

School History

Name of school ____ Grade ___________

Address of School ____

Telephone Number _______________________________________

Name of Teacher or Contact ____

Has child ever repeated a grade ______ If so, which grade? _______________

Reason for repeating grade ____

Does your child receive any special help in school? ______ Is there an IEP? _____ 504? ______

If child receives help, what kind?____

____

Has child ever had any psychological, educational or developmental evaluation in the past?____

If so, where was most recent testing? ____

Please indicate whether your child:

Easily attends school	Yes	No	_____________________________
Becomes anxious or sick before school	Yes	No	_____________________________
Refuses to go to school	Yes	No	_____________________________
Frequently visits nurse or counselor	Yes	No	_____________________________

Has difficulty riding a school bus	Yes	No	______________________________
Has difficulty with a teacher	Yes	No	______________________________
Accuses peers of bullying	Yes	No	______________________________
Has been the target of a bully	Yes	No	______________________________
Fights with peers	Yes	No	______________________________
Is disrespectful to teachers	Yes	No	______________________________
Accuses teachers of picking on them	Yes	No	______________________________
Has difficulty reading	Yes	No	______________________________
Has difficulty with math	Yes	No	______________________________
Has speech or language difficulties	Yes	No	______________________________
Has difficulty writing	Yes	No	______________________________
Has difficulty with fine motor tasks	Yes	No	______________________________
Has difficulty with attention	Yes	No	______________________________
Has difficulty remaining in a seat	Yes	No	______________________________
Has difficulty with homework	Yes	No	______________________________
Has difficulty with organization	Yes	No	______________________________

Behavioral and Emotional Functioning.

Does child currently have any behavior problems at home? If so, please explain:

____

____

Does child currently have any behavior problems at school? If so, please explain ____________

____

____

Does child have any emotional concerns, including depression or anxiety? If so, please explain

____

____

Is child currently in psychotherapy or counseling? If so, please list issues currently being addressed in therapy____

Therapist's Name and Address ____

____

If child is under the care of a psychiatrist, please list psychiatrist's name and address:

____

____

Please list any life changes or stressors that your child has experienced. These may include moving to a new home, changing schools, physical or emotional abuse, death of a relative or other traumatic experiences. Please indicate your child's age for each event. _______________

____

____

____

____

Are there any other emotional or behavioral concerns you have? _______________________

____

____

Please indicate whether any of the following apply to your child:

Generally positive mood	No	Yes	Past	Current_________________________
Easygoing or easy to get along with	No	Yes	Past	Current_________________________
Social anxiety	No	Yes	Past	Current_________________________
Shyness	No	Yes	Past	Current_________________________
Difficulty making/keeping friends	No	Yes	Past	Current_________________________
Interacts easily with peers	No	Yes	Past	Current_________________________
Has difficulty reading social cues	No	Yes	Past	Current_________________________
Frequently irritable	No	Yes	Past	Current_________________________
Sleep difficulties	No	Yes	Past	Current_________________________
Poor appetite	No	Yes	Past	Current_________________________
Overeats	No	Yes	Past	Current_________________________
Anorexia	No	Yes	Past	Current_________________________
Binge eating and/or purging	No	Yes	Past	Current_________________________
Expresses a wish to die	No	Yes	Past	Current_________________________
Self-injurious behaviors	No	Yes	Past	Current_________________________
Fears or phobias	No	Yes	Past	Current_________________________
Repeats one action/behavior	No	Yes	Past	Current_________________________
Obsessive interest in one subject	No	Yes	Past	Current_________________________
Cries easily	No	Yes	Past	Current_________________________
Mood swings	No	Yes	Past	Current_________________________
Easily angered	No	Yes	Past	Current_________________________
Bedwetting	No	Yes	Past	Current_________________________
Toileting problems	No	Yes	Past	Current_________________________
Experienced physical abuse	No	Yes	Past	Current_________________________
Experienced sexual abuse	No	Yes	Past	Current_________________________
Witnessed domestic violence	No	Yes	Past	Current_________________________
Experienced emotional abuse	No	Yes	Past	Current_________________________
Risk taking behaviors	No	Yes	Past	Current_________________________
Suicide attempt	No	Yes	Past	Current_________________________
Plays with fire	No	Yes	Past	Current_________________________
Drug or alcohol use	No	Yes	Past	Current_________________________
Problems with law enforcement	No	Yes	Past	Current_________________________
Steals	No	Yes	Past	Current_________________________
Lies	No	Yes	Past	Current_________________________
Bullies others	No	Yes	Past	Current_________________________
Harms or is cruel to animals	No	Yes	Past	Current_______________________

Psychological/Educational Assessment (Please complete if this applies to your child):
Please describe the concerns you have for yourself or your child. Also, please add any additional information that you think would be useful in this assessment:

What question(s) do you hope will be answered with this assessment?

Your name ____________________________ Relation to child _____________ Date _______

Signature__________________