CENTER FOR PEDIATRIC NEUROPSYCHOLOGY, PLLC

CHILD HISTORY FORM

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

Child's name:

Date:

Address:

Date of birth:

Age:

Home phone:

Cell phone:

Email:

Child's Preferred pronouns (circle): he/him she/her they/them Other

Religious/Cultural Affiliation?

Name of person completing form:

Relationship to child:

Child's pediatrician (most recently seen), address, and phone:

Referral Information

Who referred you for an evaluation/psychological services?

What are the main questions that you hope that we can help answer about your child?

Family Information

Parent name: ____ Age: _____ Education: _____

Occupation: ____________________________ Employer: _____________________________________

Parent name: ____ Age: _____ Education: _____

Occupation: ____________________________ Employer: _____________________________________

Parents are: ___biological ___foster ___adoptive

Parents are: ___married ___separated ___divorced ___ never married

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

Name	Age	Relationship to this child	Living at home?	Problems?

Pregnancy and Birth History

Birth weight: _______ lbs. _______ oz. Length of pregnancy: _______ weeks
Length of labor: _______ hours Apgar scores: ________________________
Delivery was: ___Vaginal ___Cesarean (reason ____________________________________)

Check any of the following health complications during the pregnancy:

__Fertility problems	__Vaginal bleeding	__Toxemia
__High blood pressure/Pre-eclampsia	__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:

Check for each problem the baby had during labor, delivery or at birth:

__Breech birth	__Cord around neck	__Meconium staining
__Lacking oxygen	__Forceps used	__Labor induced
__Fetal Distress	__Difficulty breathing	__Turned Blue
__Swallowing Problems	__Feeding Problems	__Placed in Incubator
__Seizures	__Infection	

__Jaundiced: Bilirubin lights? No Yes If yes, how long? ________________________
Length of stay in hospital: Mother: _______ days Child: _______ days
NICU Stay? No Yes

Medical problems after discharge (e.g., jaundice, fever, transfusion, surgery)?

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? Provider?
____
History of occupational therapy? When? Provider?
____

Speech

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? Provider?____

____

Was this child slow to: __learn alphabet __name colors? __count?

Other language spoken in home (besides English)? ____

Toileting

Age when toilet trained:________Urine _______Bowel _____Nighttime

Current wetting or soiling problems? Explain: ____

Medical History

Current Medical Diagnoses: ____

____ _______________________

Has vision been checked?	No	Yes	Any problems? ___________________________________
Has hearing been checked?	No	Yes	Any problems?___________________________________
History of ear tubes?	No	Yes	
Allergies/Asthma?	No	Yes	What Type? _____________________________________
Sleep well?	No	Yes	Any problems? __________________________________

Appetite/Dietary Issues:____

Child's Height: _______________ Child's Weight: ______________ Child's BMI: _________

List serious illnesses/injuries/hospitalizations/surgeries (Include incident and date).

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

CT ________________________ MRI __________________ EEG _____________________

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

Current medications, dosages, reasons, and prescribers:

Current Medical Providers and Specialty:

Family History (list problems and relationships of family members)

Learning or attention problems ____
Autism Spectrum Disorder? ____
Intellectual Disability/Developmental Delays?____
Tics/Tourette's? ____
Genetic Condition (e.g., Fragile X)? ____
Neurological illness (e.g., Alzheimer's disease, Huntington's chorea, Parkinson's disease, epilepsy)?
____
Psychiatric problems (e.g., depression, anxiety, schizophrenia, other mental illness)?
____
Alcoholism or substance abuse?
____
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?
____

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

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
___________________________	____________________________________	_______________
___________________________	____________________________________	_______________
___________________________	____________________________________	_______________
___________________________	____________________________________	_______________

Drug or Alcohol Use?	No	Yes	
History of Trauma?	No	Yes	Describe:_________________________
History of Abuse or Neglect?	No	Yes	Describe:_________________________
Victim/Witness of Domestic Abuse?	No	Yes	Physical Emotional Sexual
Concerns child will self-harm?	No	Yes	Describe:_________________________
Concerns child will harm others?	No	Yes	Describe:_________________________
Legal System Involvement?	No	Yes	Describe:_________________________

Academic History

Current school: ____

Grade: _____ Placement: Regular Education RTII/MTSS 504 Special Education/IEP

Any grades skipped or repeated? No Yes Explain:________________________________

Did your child attend preschool? No Yes Where: ________________________________

Check any of the following teachers have reported problems in.

__Reading __Attention/concentration __Spelling __Behavior

__Arithmetic __ Social adjustment __Writing

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 ____

Please check the behaviors that are concerns for your child:

___Difficulty following directions at home ___Difficulty following directions at school

___Difficulty paying attention ___Easily Distracted

___Does not complete tasks ___Disorganized

___Poor time management/planning ahead ___Hyperactive; Always on the go

___Difficulty sitting still/restless ___Impulsive; Does things without thinking

___Argues a lot ___Does not follow rules

___Fights with other children ___Defiant; Says no to adults

___Hurts people or animals intentionally ___ Whines or complains frequently

___Seems irritable ___ Has low frustration tolerance

___Is sad, unhappy, depressed ___Has temper tantrums: _____Per Week ____Length

___Seems to feel badly about themself ___Anxious/Worries that bad things may happen

___Has many fears ___Freq complaints of stomachache, headache, etc.

___Sleeping problems ___ Talks about hurting him/herself or others

Please check the behaviors that are concerns for your child (continued):

___Tunes out; Seems to be in own world

___Is not able to share toys and space

___Cannot take turns in play

___Does not pretend play

___Has unusual movements

Describe: ______________________

___Makes noises (throat clearing, grunting)

Describe: ______________________

___Seeks sensory input

___Stubborn/Gets "stuck" on ideas/Rigid thinking

___Lacks understanding of "social cues"

___Doesn't interact with peers

___Doesn't imitate actions

___Does not play with toys as intended

___Has interests that are intense and take up time

Describe: ____________________________

___Is bothered by noise, touch, smells, tastes

Describe: ______________________

___Cannot tolerate changes in routine

What are your child's strengths?

Additional Comments?