CHILDHOOD HISTORY FORM Date _____

Client's Name			Preferred Name	
Birth Date			Age	Gender
Address				
City	ST	Zip		Phone
School		Grade	Special Placement (if any)	

Client presently lives with:

☐ Biological parent(s) ☐ Stepparent(s) ☐ Adoptive parent(s)
☐ Foster parents(s) ☐ Grandparent(s) ☐ Other _____

Name of Referral Source: _____ Phone _____

What are the current concerns: (List in order of importance)
1.
2.
3.
How has the family attempted to deal with these concerns?
What do you hope to accomplish as a result of this evaluation?

What are the strengths and resources of the family or families?
What are the struggles of the family or families?

FAMILY

PARENT 1 Name:	
Occupation	Best Phone #
School: Highest grade completed	
Learning problems	
Attention problems	
Behavior problems	
Medical problems	

Have any of your blood relatives experienced problems similar to those your child is experiencing? If so, describe

PARENT 2 Name:	
Occupation	Best Phone #
School: Highest grade completed	
Learning problems	
Attention problems	
Behavior problems	
Medical problems	

Have any of your blood relatives experienced problems similar to those your child is experiencing? If so, describe

SIBLINGS		
Name	*Age*	*Medical, Social or School Problems*
1		
2		
3		
4		
5		

PREGNANCY – Indicate any complications	
Excessive vomiting	Hospitalization required
Excessive staining/blood loss	Threatened miscarriage
Infection(s) (specify)	
Toxemia	Operation(s) (specify)
Other illness(s) (specify)	
Smoking during pregnancy	# of cigarettes per day
Alcohol consumption during pregnancy	
Describe if beyond an occasional drink	
Medications taken during pregnancy	
X-ray studies during pregnancy	
Duration of pregnancy (weeks)	
DELIVERY	
Type of Labor □ Spontaneous □ Induced Duration (hours)	
Type of Delivery □ Normal □ Breech □ Cesarean	
Complications □ Cord around neck □ Hemorrhage	
Birth weight	
POST DELIVERY PERIOD	
□ Jaundice □ Cyanosis (turning blue) □ Incubator care	
Infection (specify)	
Numbers of days infant was in the hospital after delivery	

INFANCY	
Were any of the following present – to a significant degree – during the first few months of life? If so, describe	
Did not enjoy cuddling	
Was not calmed by being held or stroked	
Difficult to comfort	
Colic	Excessive restlessness
Excessive irritability	
Diminished sleep	
Frequent head banging	
Difficult nursing	
Constantly into everything	

TEMPERAMENT
Please rate the following behaviors as your child appeared during infancy and toddlerhood:
Activity level – how active has your child been from an early age?
Distractibility – how well did your child pay attention?
Adaptability – how well did your child deal with transition and change?
Approach/Withdrawal – how well did your child respond to new things (i.e., places, people, food,

etc.)?
Intensity – Whether happy or unhappy, how aware are others of your child's feelings?
Mood – What was your child's basic mood?
Regularity – How predictable was your child in patterns of sleep, appetite, etc.?

MEDICAL HISTORY		
If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.		
Childhood diseases (describe ages and any complications)		
Operations		
Hospitalization for illness		
Head injuries		
Convulsions	☐ with fever	☐ without fever
Coma		
Persistent high fevers		
Eye problems		
Tics (i.e., eye blinking, sniffing, any repetitive, non-purposeful movements)		
Ear problems		
Allergies or Asthma		
Poisoning		
Substance abuse		
SLEEP		
Does your child settle down to sleep?		
Sleep through the night without disruption?		
Experience nightmares, night terrors, sleep walking, sleep talking?		
Is your child a very restless sleeper?		
Does your child snore?		
Appetite:	☐ good	☐ poor

PRESENT MEDICAL STATUS	
Height	Weight
Present illnesses for which your child is being treated	
Medications child is taking on an ongoing basis	

DEVELOPMENTAL MILESTONES					
If you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall exactly, check one of the columns on the right.					
	Age	or	*Early*	*Normal*	*Late*
Smiled					
Sat without support					
Crawled					
Stood without support					
Walked without assistance					
Spoke first words					
Said phrases					
Said sentences					
Bladder trained, day					
Bladder trained, night					
Bowel trained, day					
Bowel trained, night					

	Age	or	*Early*	*Normal*	*Late*
Rode tricycle					
Rode bicycle (without training wheels)					
Buttoned clothing					
Tied shoelaces					
Named colors					
Named coins					
Said alphabet in order					
Began to read					

COORDINATION – **By AGE 7**			
rate your child on the following skills:	*Good*	*Average*	*Poor*
Walking			
Running			
Throwing			
Catching			
Shoelace tying			
Buttoning			
Writing			
Athletic abilities			
Excessive number of accidents compared to other children?			

COMPREHENSION AND UNDERSTANDING – **By Age 7**
Did you consider your child to understand directions and situations as well as other children? If not, why not?
How would you rate your child's overall level of intelligence compared to other children? □ Below Average □ Above Average □ Average

PEER RELATIONSHIPS
Does your child seek friendships with peers?
Is your child sought by peers for friendship?
Does your child play with children primarily his/her own age? □ younger □ older □
Describe briefly any problems your child may have with peers

Major changes and stressful events your child has experienced:		
Event	Date	Details
Change in residence		
Divorce, separation, remarriage		
Death or loss of family member/friend		
Serious illness		
Other:		

SCHOOL HISTORY			
Were you concerned about your child's ability to succeed in kindergarten? If so, please explain □ No □ Yes			
Rate your child's school experiences related to academic learning:	*Good*	*Average*	*Poor*
Nursery school			
Kindergarten			
Current grade			

To the best of your knowledge, at what grade level is your child/teen functioning?

Reading_____Spelling_____Arithmetic _____

Has your child ever had to repeat a grade? If so, when?

Present class placement: □ regular class □ special class (if so, specify)

Kinds of special counseling or remedial work your child is currently receiving:

Describe briefly any academic school problems:

Rate your child's school experiences related to behavior:	*Good*	*Average*	*Poor*
Nursery school			
Kindergarten			
Elementary			
Current grade			
Comments:			

CURRENT SCHOOL BEHAVIOR

Does your child/teen's teacher describe any of the following as significant classroom problems?

- ☐ Doesn't sit still in his/her seat
- ☐ Frequently gets up and walks around the classroom
- ☐ Shouts out. Doesn't wait to be called on
- ☐ Won't wait his/her/their turn
- ☐ Doesn't cooperate well in group activities
- ☐ Typically does better in a one-to-one relationship
- ☐ Doesn't respect the rights of others
- ☐ Doesn't pay attention during storytelling or show and tell

Describe briefly any *other* classroom behavior problems

As best you can recall, please use the following space to provide a general description of your child's academic progress in each grade. Use the back of this form if extra space is needed.

CURRENT HOME BEHAVIOR

All children exhibit, to some degree the behaviors listed below. Check those that you believe your child exhibits to an ***excessive or exaggerated degree*** when compared to others his,her or their own age.

- ☐ Has difficulty remaining seated when required to do so
- ☐ Easily distracted by extraneous stimulation
- ☐ Has difficulty awaiting his turn in games or group situations
- ☐ Blurts out answers to questions before they have been completed
- ☐ Has problems following through with instructions (usually not due to opposition or failure to comprehend)
- ☐ Has difficulty paying attention during tasks or play activities
- ☐ Shifts from one uncompleted activity to another
- ☐ Has difficulty playing quietly
- ☐ Often talks excessively
- ☐ Interrupts or intrudes on others (often not purposeful or planned but impulsive)
- ☐ Does not appear to listen to what is being said

☐ Loses things necessary for tasks or activities at home
☐ Boundless energy
☐ Poor judgment
☐ Impulsivity (poor self-control)
☐ History of temper tantrums
☐ Temper outbursts
☐ Frustrates easily
☐ Sloppy table manners
☐ Sudden outbursts of physical action toward other children
☐ Acts like he/she is driven by a motor
☐ Wears out shoes more frequently than siblings
☐ Excessive number of accidents
☐ Doesn't seem to learn from experience
☐ Poor memory

How well does your child work for a short-term reward?How well does your child work for a long-term reward?

Does your child create more problems, either purposeful or non-purposeful, within the home setting than his, her or their siblings?

Does your child have difficulty learning from his/her/their experiences?

Types of discipline you use with your child

Is there a particular form of discipline that has proven effective?

Have you participated in a parenting class or obtained other forms of information concerning discipline and behavior management?

SENSORY CONCERNS			
Does your child exhibit the following behaviors?			
Gross Motor Skills	Frequently	Sometime	Never
Seems weaker or tires more easily than others of the same age			
Appears stiff and awkward in movements			
Clumsy or seems not to know how to move body, bumps into things			
Tendency to confuse right and left body sides			
Reluctant to participate in sports or physical activity; prefers table activity			
Fine Motor Skills			
Difficulty drawing, coloring, copying, cutting. Avoids these activities			
Poor pencil grasp; drops pencil frequently			
Tight pencil grasp; tires quickly in writing or other pencil & paper tasks			
Hand dominance not well established (after age six)			
Difficulty in dressing; clothing off or on, buttons, zippers, tying bows			
Touch			
Seems overly sensitive to being touched; pulls away from light touch			
Has trouble keeping hands to self, will poke or push other children			
Touches things constantly; "learns" through his/her/their fingers			
Avoids putting hands in messy substances (clay, finger paint, paint)			
Movement and Balance			
Fearful moving through space (teeter-totter, swing)			
Poor balance in motor activities			
Seeks quantities of movement including swinging, spinning, bouncing			
Seems to fall frequently			

Visual Perception			
Difficulty naming or matching colors, shapes or sizes			
Difficulty in completing puzzles, trial and error placement of pieces			
Reversal in words or letters after first grade			
Difficulty coordinating eyes for following a moving object; keeping place in reading, copying from board to desk			
Auditory/Language			
Appears overly sensitive to loud noises (e.g., bells, toilet flush)			
Is hard to understand when he/she/they speaks			
Appears to have difficulty understanding what is said			
Has trouble following 2-3 step commands			
Emotional/Social			
Does not accept changes in routine easily			
Boredom is intolerable			
Trouble with sleep; falling or staying asleep			
Tends to withdraw from groups – plays on the outskirts			
Avoids eye contact			

INTERESTS AND ACCOMPLISHMENTS
What are your child's main hobbies and interests?
What are your child's areas of greatest accomplishment?
What does your child enjoy doing most?
What does your child dislike doing most?
What do you like about your child/teen?

List names and numbers of any other professionals consulted (including family doctor):