Patient's History/Information

Child's History/Information

Name: ______________________________ M F Age: _________ Birthdate: ______________

Referred by: _________________________________ Specialty: ____________ Date: ___________

Person Completing this Form: ______________________________ Relationship to patient: ____________

Why are you seeking this evaluation? ____

____

Who is legally responsible for the patient: ____

CURRENT CONCERNS ABOUT THE CHILD (*Please circle all that apply*)

aggression	peer relationships	school or work environment	over-activity
language abilities	toileting	preoccupations	temper tantrums
biting	hitting	self-injury	sleep problems
appetite/food selections	inattention	self-help (independence) skills	motor skills
depressed or anxious	medication	muscle tone	

self-stimulatory behaviors: rocking, spinning, flapping hands, close visual inspection

Other: ____

CHILD'S CURRENT LIVING SITUATION

With whom does the child currently reside? (*Please circle all that apply*.)

Biological Mother	Biological Father	Step-mother	Step-father
Adoptive Mother	Adoptive Father	Foster Mother	Foster Father

Other (describe: ____)

Complete the following for the child's BIOLOGICAL PARENTS to the best of your ability, even if the child was NOT raised by the biological parents.

Biological Mother's name: ______________________________ Age: _____

If deceased, age at time of death: _____ Cause of death: ________________________

Occupation: _________________________ Ethnic/Cultural Background: _________________________

Day Phone: ________________________________ Evening Phone: ___________________________

Biological Father's name: ______________________________ Age: _____

If deceased, age at time of death: _____ Cause of death: ________________________

Occupation: _________________________ Ethnic/Cultural Background: _________________________

Day Phone: ________________________________ Evening Phone: ___________________________

If the child resides with parents OTHER than biological parents, please describe them here.

Parent One's name: ____Gender: _____

Age: ______ If deceased, age at time of death: ______ Cause of death: _________________________

Relationship to patient: .. Adoptive Parent .. Step-Parent .. Foster Parent .. Other: ____________

Occupation: __________________________ Ethnic/Cultural Background: __________________________

Day Phone: _________________________________ Evening Phone: ____________________________

Parent Two's name: ____Gender: _____

Age: ______ If deceased, age at time of death: ______ Cause of death: _________________________

Relationship to patient: .. Adoptive Parent .. Step-Parent .. Foster Parent .. Other: ____________

Occupation: __________________________ Ethnic/Cultural Background: __________________________

Day Phone: _________________________________ Evening Phone: ____________________________

If child does not live with BOTH biological parents, who has legal custody of the child? _____________

How often does the other biological parent see this child? _____________________________________

Approximate date of divorce/separation: ____________

If child is with ADOPTIVE parent, age child was first in home: _____ Date of legal adoption: ________

What has the child been told about the adoption? ____

If your child spends a significant amount of time with a caregiver other than someone described above (i.e., spends more than 4 hours/day) EXCLUDING school personnel, please complete the following information for that person here:

Name: ____ Age: ______ Birthdate:

Relationship to child: ____________________ Ethnic/Cultural Background: ______________________

Occupation: _____________________________

If the child was ADOPTED, age child was first in the home: ______ Age at time of adoption: ______

Are there any custody-related legal proceedings in progress or planned? Yes No

Other individuals living with client:

Name	Age	Sex	Relationship

What languages does the patient use (List PRIMARY language first): ___________________________

What other languages is the patient exposed to? ____

HISTORY (If re-evaluation, please skip to "Checklist" on page 5.)

Prenatal/Pregnancy

Did the biological mother have any of the following immediately before/after or during pregnancy?

.. Maternal injury. Describe: ____

.. Hospitalization during pregnancy. Reason: ____

.. X-rays during pregnancy. What month of pregnancy? ___________

Did the biological mother have any of the following during pregnancy? (*Please circle all that apply*.)

Emotional problems	Infections	Anemia	Premature Labor
Rashes	Bed-rest	Toxemia	Difficulty in conception
Flu	Vaginal bleeding	Kidney disease	Gained more than 35 pounds
Excessive swelling	Measles/German measles	Headaches	High blood pressure
Strep Throat	Threatened miscarriage	Rh incompatibility	Excessive nausea/vomiting
Severe cold	Urinary problems	Other virus ___________________	

Special diet, describe: ___________________________ .. Meds: _____________________

Other: ____

Mother's age at conception: __________

Did the mother have previous pregnancies? .. No .. Yes, how many, including miscarriages? ______

Did mother receive prenatal care during this pregnancy? .. No .. Yes, beginning at month ______

During the pregnancy, was the baby: Very active Average Rather quiet

Were there any unusual changes in the baby's activity level during pregnancy? Yes No

Please describe changes: ____

Delivery

Was infant born full-term? Yes No

If premature, how early? ________________________If overdue, how late? _________________________

Birth weight: Apgars: __________1 min __________5 min

Type of anesthetic used: None Spinal Local General

Length of active labor: __________ Describe any complications during delivery: _____________________

____

Circle all of the following that applied to the delivery:

Spontaneous Breech Forceps Head first Multiple births Cord around neck

Induced; Reason: ____

Cesarean; Reason: ____

Which of the following applied to the infant? (*Circle all that apply*)

Breathing problems Required oxygen Required incubator Feeding problems Sleeping problems

Infection Rash Excessive crying Sleeping problems Seizures/convulsions

Bleeding into the brain

Jaundice (Were Bilirubin lights used? No Yes – If yes, how long? __________________________)

Did the infant require: X-Rays CT scans Blood transfusions

Was child placed in the Neonatal Intensive Care Unit? No Yes -- If yes, why and for how long?

____

Length of stay in hospital: Mother ___________ Infant ___________

Developmental History

During this child's first 3 years, were any special problems noted in the following areas? (*Circle all that apply*.)

Irritability Breathing problems Colic Difficulty sleeping

Eating problems Temper tantrums Failure to thrive Excessive crying

Withdrawn behavior Poor eye contact Early learning problem Destructive behavior

Convulsions/Seizures Unable to separate from parent

Other ____

Developmental Milestones

Indicate age when child:

__________sat unaided __________walked __________started solid foods

__________bladder trained – day __________bladder trained – night __________bowel trained

__________rides tricycle __________rides bike

Can your child be described as clumsy/uncoordinated? Yes No

Having fine motor delay? Yes No

Which hand does the patient use for: Writing/drawing? ________ Eating? ________ Cutting? ________

Current eating behavior: Normal Picky Eats too much Weight loss/gain

Oral Motor concerns None Difficulty swallowing Drooling Gagging

Language development

Indicate age when patient begin babbling, such as repeating syllables, in attempts to communicate?:_______

using single words? ____________ using phrases/short sentences? ____________

Have there been any hearing concerns? No Yes

Adaptive Skills

Feeds self ☐ No ☐ Yes, beginning at age _______

Dresses self ☐ No ☐ Yes, beginning at age _______

Bathes self ☐ No ☐ Yes, beginning at age _______

Helps with household chores ☐ No ☐ Yes, beginning at age _______

Knows phone number and address ☐ No ☐ Yes, beginning at age _______

Says “please” and “thank you” ☐ No ☐ Yes, beginning at age _______

Tells time accurately ☐ No ☐ Yes, beginning at age _______

Feeds self ☐ No ☐ Yes, beginning at age _______

Dresses self ☐ No ☐ Yes, beginning at age _______

Bathes self ☐ No ☐ Yes, beginning at age _______

Helps with household chores ☐ No ☐ Yes, beginning at age _______

Knows phone number and address ☐ No ☐ Yes, beginning at age _______

Says “please” and “thank you” ☐ No ☐ Yes, beginning at age _______

Tells time accurately ☐ No ☐ Yes, beginning at age _______

Has the child ever lost skills, which at one time he/she was able to perform No Yes

If yes, please explain ____

When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?

☐ Time out ☐ Loss of allowance/privileges ☐ Physical punishment ☐ Yelling

☐ Ignoring ☐ Grounding ☐ Other, describe ______________________

Who is mainly in charge of discipline? ____

What do you find most difficult about raising your child? ___________________________________

Family Changes and Stressors

What are the major family stresses the family and/or child is currently experiencing or has experienced within the last year? (*Circle all that apply*)

Marital discord/fighting   Separation/Divorce   Birth/Adoption of a child   Parent-Patient conflict
Parent/sibling death   Patient-child conflict   Financial problems   Involved in court
Family deployed extensively   Move/Relocation   Physical abuse   Sexual abuse
Family emotionally/mentally ill   Family substance abuse   Loss of job
Involved with Social Services/Protective Services   Other: ______________________

Checklist

Please mark any of the following that describe the patient currently or in the past:

Speech

Current Past

_____ _____ slow speech development
_____ _____ difficult to understand speech
_____ _____ babbles
_____ _____ says some words/phrases over and over again
_____ _____ has language of his/her own (may sound like foreign language/jargon)
_____ _____ repeats questions, instead of answering them
_____ _____ repeat dialogue from movies or songs verbatim

Current Past

_____ _____ unusual tone or pitch
_____ _____ seldom speaks unless prompted
_____ _____ doesn't understand without gestures

Relating with other people

Current Past

_____ _____ not cuddly as baby
_____ _____ "in a world of his/her own"
_____ _____ "clings" to people
_____ _____ very fearful of strangers

Current Past

_____ _____ prefers to be by self
_____ _____ aloof, distant
_____ _____ doesn't recognize parent
_____ _____ likes to be held

Imitation

Current Past

_____ _____ doesn't imitate waving "bye-bye", "patty cake", etc. (physical imitation)
_____ _____ doesn't repeat words said to him
_____ _____ doesn't repeat words generally, but usually does what he is asked to do
_____ _____ doesn't use common gestures

Response to Sounds, Speech

Current Past

_____ _____ often ignores sounds

_____ _____ afraid of certain sounds

_____ _____ often ignores what is said to him/her (speech)

_____ _____ seems to hear distant or soft sounds that most other people don't hear or notice

_____ _____ really likes certain sounds (music, motors, etc.)

_____ _____ unpredictable response to sounds (sometimes reacts, sometimes doesn't)

_____ _____ responds to speech and sounds like other people of the same age

Visual Response

Current Past

_____ _____ stares vacantly around room

_____ _____ likes to look at self in mirror

_____ _____ stares at parts of his/her body (e.g. hands)

_____ _____ is distracted by lights – stares at certain lights

_____ _____ very interested in small parts of an object

_____ _____ seems to look at things out of the corner of his/her eye and not by looking directly at them

_____ _____ often avoids looking at people when they are talking to him

Current Past

_____ _____ often doesn't look at anything

_____ _____ likes to look at shiny objects

_____ _____ turns lights on and off repeatedly

Other Senses

Current Past

_____ _____ puts many objects in mouth

_____ _____ overreacts to pain

_____ _____ doesn't notice pain as much as most people

_____ _____ smells objects not usually smelled or smells unfamiliar objects

_____ _____ tries to chew or eat objects that are not supposed to be eaten (for example, clay)

Current Past

_____ _____ licks objects

_____ _____ likes vibrations

Emotional Responses

Current Past

_____ _____ temper tantrums

_____ _____ cries/seems sad for no reason

_____ _____ moods change very quickly, sometimes for no apparent reason

_____ _____ often has a blank expression on face – little response to what is happening around

Current Past

_____ _____ over-responds to situations

_____ _____ laughs/smiles for no reason

Medical History

Has the patient ever had:

Head injury Yes No If yes, age experienced head injury and description of head injury:

____

Loss of consciousness (LOC) Yes No If yes, age experienced LOC and description of LOC:

____

Allergies to food/medication List: ____

Surgery Age _____ Reason ______________ Describe ______________________________

____

☐ Ear Infections: Age ____ Describe ____

Is the child up to date on immunizations? ☐ Yes ☐ No, Why not? ______________________________

Doctors seen (check all that apply) Doctors seen now or in the past (check all that apply)

General Physician – Date of last visit: _________ Diagnosis: ______________________________

Developmental Pediatrician – Date: ______ Diagnosis: ___________________________________

Neurologist – Date: __________ Diagnosis: ____

suspected seizures, describe: ____

seizures diagnosed, type: ____

Genetics – Date: _______ Diagnosis: ____

Psychiatry – Date: ________ Diagnosis: ____

Gastroenterology – Date: ________ Diagnosis: ____

Endocrinology – Date: _________ Diagnosis: ____

Diagnostic Testing *(check all that apply)*

EEG (brain wave test) – Date: _______ Results: ______________________________________

MRI – Date: _______ Results: ____

CT Scan – Date: _________ Results: ____

Ophthalmology Evaluation – Date: ________ Results: __________________________________

Chromosomal/DNA testing (Genetic) – Date: ________ Results: __________________________

Other; Describe: ____

Medication history

CURRENT medications (PLEASE NOTE: **DO ADMINISTER** child's regularly scheduled medications, if any, on the day of appointment)

Name of medication Dose & Frequency Date Started Reason Effectiveness

____

____

____

____

Who prescribes these medications? ______________________ Date of last visit: ____________

Please also list any medications the patient has been on in the PAST:

Name of medication   Date Started   Reason   Effectiveness

____

____

____

____

____

Who prescribed past medications? ______________________

Family History

Have any members of the biological mother's or biological father's families had any of the following problems or disorders (*Please circle all that apply*):

Birth Defect	Chromosomal/genetic disorder	Obsessive Compulsive Disorder
Cerebral Palsy	Severe head injury	High blood pressure
Kidney disease	Migraine headaches	Multiple Sclerosis
Physical handicap	Nervousness/Anxiety	Stroke
Tuberous Sclerosis	Alzheimer's disease	Hemophilia
Huntington's chorea	Muscular dystrophy	Parkinson's disease
Sickle-cell anemia	Cancer	Seizures/epilepsy
Diabetes	Heart disease	Food allergies
Alcohol/drug abuse	Depression	Physical/Sexual abuse
Schizophrenia	Intellectual Disability	Speech/language delay
Autism/PDD	Reading problem	Other learning disability
Emotional disturbance/mental illness	Bipolar/manic-depressive disorder	Tics/Tourette's syndrome

Antisocial Behavior (assaults, thefts, arrests, etc.)

Childhood behavior disorder (aggressive/defiant/ADHD)

Other: ____

Has anyone in the family ever received special education services?   No   Yes, for what reason?

____

School History

Current school: ______________________ School district: ____________________ Grade: ________

Has your child best tested for special education services in school? Yes No

Psychological/Cognitive – Date: __________ .. Academic – Date: ____________________

Speech/Language – Date: _______________ .. Other: _______________ Date: _________

Was/Is your child on an IEP (Individual Education Plan)? _____ For what reason? ________________

Type of placement/class (*Circle all that apply*) General Education Content Mastery Resource

Self-contained Behavior adjustment class Other: _____________________________________

SPECIAL EDUCATION SERVICES

Child's age when school services began: __________ Age when discontinued: __________

Individual Education Plan (IEP) eligibility category(ies): ______________________

Which services is the child CURRENTLY receiving through the SCHOOL DISTRICT? (*Circle all that apply*)

Speech therapy Occupational therapy Physical therapy

Adaptive Physical Education Discrete Trial Training (DTT/ABA) Social Skills

Other, describe: ____

Early Childhood (ECI): (Please bring copies of your most recent ECI Individual Family Service Plan (IFSP), and relevant reports)

Private Services (Please bring copies of relevant reports to your first appointment.)

Speech therapy Age when began: ______________

Occupational therapy Age when began: _____________

Physical therapy Age when began: ______________

Social Skills Age when began: ______________

Vocational Assistance Age when began: ______________

Psychotherapy Age when began: ______________

Other, describe: ____