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Child History / Information

Child's Name:_____ Date: _____

Address (Street, City, State, Zip): _____

_____

Parent's or guardian phone: (H) _____ (W) _____

Age _____ Birthdate _____ Religion _____

Sex _____ Ethnic or racial background _____

Grade and school _____

Special Placement (if any) _____

Hand child uses for writing or drawing: Right ____ Left ____ Switches between them ____

Primary language _____ Secondary language _____

Medical diagnosis (if any) (1) _____

(2) _____

(3) _____

(4) _____

Who referred the child for this testing? _____

_____

Briefly describe the problem(s)

(1) _____

(2) _____

(3) _____

(4) _____

What specific questions would you like answered by this evaluation?

(1) _____

(2) _____

(3) _____

(4) _____

THIS FORM HAS BEEN COMPLETED BY:

Name _____ Relationship to child _____

Address _____

Phone (H) _____ (W) _____

CURRENT LIVING ARRANGEMENT

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

Biological Mother	Step-Mother	Adoptive Mother	Foster Mother
Biological Father	Step-Father	Adoptive Father	Foster Father

Other: _____

Siblings (Please list whether the siblings live with the child or not)

Name	Age	Sex	Full/Step/Half	Grade	In Child's Home?

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

_____

How often does the other biological parent see the child? _____

Number of years married/together: ____ Approximate date of divorce/separation:_____

If the child is with **ADOPTIVE** parent, age when child was first in home: _____

Is the child aware of the adoption? _____

Does the child spend a significant amount of time (e.g. more than 4 hours/day) EXCLUDING school personnel, therapists, etc, please provide the following information for that person here:

_____

_____

_____

_____

DEVELOPMENTAL HISTORY

Prenatal/Pregnancy

Mother's age at birth: _____ Father's age at birth: _____

Before the pregnancy, what medications (prescribed or over-the-counter) did the mother take?

List all medications used: _____

While pregnant, what medications (prescribed or over-the-counter) did the mother take?

List all medications used: _____

How often did the mother see her doctor during the pregnancy?

Regularly (as scheduled by the doctor) ____ Rarely ___ Not at all ____

During the pregnancy, which of the following did the mother use?

		Amount and Daily Frequency
____	Alcohol	_____
____	Caffeine (coffee, colas, etc.)	_____
____	Marijuana	_____
____	Recreational drugs (cocaine, heroin, etc.)	_____
____	Tobacco	_____

During pregnancy, the mothers diet was: Good ___ Poor ____

If poor, explain: _____

The mother's general physical health during the pregnancy was: Good ____ Poor ____

If poor, explain: _____

About how much weight did the mother gain while she was pregnant? _____ lbs.

During this pregnancy, check all the mother had:

_____ Accident

_____ Anemia

_____ Bleeding (severe or frequent spotting)
_____ Diabetes
_____ High blood pressure
_____ Illnesses or infections
_____ Preeclampsia, eclampsia, or toxemia
_____ Psychological problems
_____ Surgery
_____ Vomiting (severe or frequent)
_____ Other (please explain): _____

During the pregnancy, was the baby: Very active Average Rather quiet
Were there any unusual changes in the baby's activity level during pregnancy? No Yes
Did the biological mother have any complications during pregnancy? Yes No
If yes, describe: _____

Delivery
Was infant born full-term? Yes No
If premature, how early? _____ If overdue, how late? _____
Birth Weight: _____ Apgars: at 1 minute _____ at 5 minutes _____
Type of anesthetic used: None Spinal Local General
Length of active labor: _____
Were there any complications during delivery ? No Yes, describe: _____
_____

Which of the following 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? Breathing problems Required oxygen Rash
Jaundice Excessive crying Infection
Sleeping problems Required incubator
Seizures/convulsions Unusual appearance
Bleeding into the brain

Did the infant require: X-Rays CT scans Blood transfusions Placement in the NICU
If so, for how long? ____
Length of stay in hospital: Mother _____ Infant _____

Early Development & Milestones
During the child's first three years, were any special problems noted in the following areas?

Irritability	Breathing problems	Colic
Difficulty sleeping	Eating problems	Temper tantrums
Failure to thrive	Excessive crying	Withdrawn behavior
Poor eye contact	Early learning problems	Destructive behavior
Convulsions/Seizures	Twitching	Unable to separate from parent

Other: _____

Indicate age when child:

_____ sat unaided	_____ crawled	_____ walked
_____ started solid foods	_____ fed self with spoon	_____ gave up bottle
_____ bladder trained – day	_____ bladder trained – night	_____ bowel trained
_____ rides tricycle	_____ rides bike	

Which hand does your child 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 child began babbling, such as repeating syllables, in attempts to communicate: _____
Using single words: _____ Using phrases / short sentences: _____
Have there been any hearing concerns? No Yes Date of any hearing test(s): _____

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 _____

Has the child ever lost skills, which at one time he or 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 past year? (circle all that apply)

Marital discord / fighting	Separation	Divorce
Birth / Adoption of another child	Sibling conflict	Parent-child conflict
Custody disagreement	Single-parent family	Parent / sibling death
Parent deployed extensively	Parent emotionally / mentally ill	Involved in juvenile court
Abandonment by parent	Financial problems	Parent substance abuse
Child neglect	Physical abuse	Sexual abuse

Parent disagreement about child rearing Involvement with Social Services / Child Protective Services

Developmental Concerns

Please mark any of the following areas that describe your child currently or in the past:

Speech

Current	Past	
_____	_____	had slow speech development
_____	_____	has unusual tone or pitch
_____	_____	has difficult to understand speech
_____	_____	seldom speaks unless prompted
_____	_____	repeats words or phrases over and over again
_____	_____	repeats questions instead of answering them
_____	_____	repeats dialogue from movies or songs excessively
_____	_____	has difficulty initiating or sustaining reciprocal conversation
_____	_____	talks excessively about favorite topics
_____	_____	has trouble adapting to change in topic during conversation

Relating to other people

Current	Past	
_____	_____	was not cuddly as a baby
_____	_____	"in a world of his or her own"
_____	_____	"clings" to people
_____	_____	is very fearful of strangers
_____	_____	has trouble developing and maintaining friendships
_____	_____	refers to acquaintances as "friends"
_____	_____	is often teased or bullied
_____	_____	prefers play with younger children rather than peers
_____	_____	plays better with older children or adults rather than peers
_____	_____	wants friends but has poor grasp of the concept of friendship
_____	_____	prefers to be alone
_____	_____	is aloof or distant
_____	_____	doesn't recognize parent
_____	_____	has difficulty using eye contact, facial expressions, and gestures to augment verbal communication
_____	_____	directs other children during play and is not interested in the ideas or suggestions of others

Response to Sounds and Speech

Current	Past	
_____	_____	often ignores sounds
_____	_____	is afraid of certain sounds
_____	_____	often ignores what is said to him or her
_____	_____	seems to hear distant or soft sounds that most other people don't hear or notice
_____	_____	really likes certain sounds (music, motors, etc.)
_____	_____	has unpredictable response to sounds (e.g. sometimes reacts, sometimes doesn't)
_____	_____	has trouble with non-literal language, such as idioms (e.g. "Let's hit the road")

Visual Response

Current	Past	
_____	_____	stares vacantly around the room
_____	_____	likes to look at self in mirror
_____	_____	likes to look at shiny objects
_____	_____	stares at parts of his or her body (e.g. hands)
_____	_____	seems to look at things out of the corner of his or her eye and not looking directly at them
_____	_____	plays with lights by turning them on and off repeatedly
_____	_____	often avoids looking at people when spoken to
_____	_____	is distracted by lights – stares at certain lights
_____	_____	is very interested in small parts of objects

Other Senses

Current	Past	
_____	_____	puts many objects in mouth
_____	_____	licks objects
_____	_____	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)

Emotional Responses

Current	Past	
_____	_____	temper tantrums
_____	_____	cries / seems sad for no reason

_____ _____ laughs / smiles for no reason
_____ _____ mood changes very quickly, sometimes for no apparent reason
_____ _____ often has blank expression on face – little response to what is happening around him or her

Behavior Patterns

Current Past

_____ _____ has intense interest in a certain topic
_____ _____ is overly sensitive to change or disruption of routine
_____ _____ has limited flexibility, for example food selection, clothing or certain rituals
_____ _____ has repetitive motor mannerisms, such has flapping hands or spinning

School Performance (if applicable)

Current Past

_____ _____ is performing below grade level in some or all subjects
_____ _____ classroom behavior interferes with academic performance
_____ _____ difficulty with peer relations
_____ _____ resists homework
_____ _____ has poor organization
_____ _____ completes homework but fails to turn it in

Awareness and Concentration

Current Past

_____ _____ Easily distracted by: Sounds ___Sights ___Physical Sensations ___
_____ _____ Mind appears to go blank at times
_____ _____ Loses train of thought
_____ _____ Difficulty concentrating on what others ay, but can sit in front of a TV for long periods
_____ _____ Attention starts out OK but can't keep it up
_____ _____ Other attention or concentration problems: _____

Memory

Current Past

_____ _____ Forgets where he/she leaves things
_____ _____ Forgets things that happened recently (e.g., last meal)
_____ _____ Forgets things that happened days/weeks ago
_____ _____ Forgets what he/she is supposed to be doing
_____ _____ Forgets names more than most people do
_____ _____ Forgets school assignments
_____ _____ Forgets instructions
_____ _____ Other memory problems _____

Below, circle the number that best describes your child's behavior and has been present for at least the **past 6 months**. 0 = Never or very rarely, 1 = Sometimes, 2 = Often. 3 = Very Often or almost Always

Fails to give close attention to details or makes careless mistakes in schoolwork	0	1	2	3
Has difficulty sustaining attention in tasks or play activities	0	1	2	3
Does not seem to listen when spoken to directly	0	1	2	3
Does not follow through on instructions and fails to finish work	0	1	2	3
Has difficulty organizing tasks and activities	0	1	2	3
Avoids tasks (e.g., schoolwork, homework) that require mental effort	0	1	2	3
Loses things necessary for tasks or activities	0	1	2	3
Is easily distracted	0	1	2	3
Is forgetful in daily activities	0	1	2	3

Fidgets with hands or feet or squirms in seat	0	1	2	3
Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
Runs about or climbs excessively in situations in which it is inappropriate	0	1	2	3
Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
Is "on the go" or acts as if "driven by a motor"	0	1	2	3
Talks excessively	0	1	2	3
Blurts out answers before questions have been completed	0	1	2	3
Has difficulty awaiting turn	0	1	2	3
Interrupts or intrudes on others	0	1	2	3
Loses temper	0	1	2	3
Argues with adults	0	1	2	3
Actively defies or refuses to comply with adults' requests or rules	0	1	2	3
Deliberately annoys people	0	1	2	3
Blames others for his/her mistakes or misbehavior	0	1	2	3
Is touchy or easily annoyed by others	0	1	2	3
Is angry and resentful	0	1	2	3
Is spiteful or vindictive	0	1	2	3

Additionally, has the child engaged in any of the following over the last 12 months

_____ Steals things without people knowing on several occasions
_____ Often runs away from his parents' home and stays away overnight
_____ Easily lies to others
_____ Fire setting
_____ Doesn't go to school
_____ Breaks into other people's property
_____ Destroys other people's property in some manner other than by fire
_____ Is cruel to animals
_____ Has forcible sexual relations with others
_____ When fighting, has used a weapon on more than one occasion
_____ Starts fights with others
_____ Will steal directly from people
_____ Is cruel to other people

MEDICAL HISTORY

Has your child ever had:
Head injury: Age ____ Describe _____
Loss of consciousness: Age ____ Describe _____
Allergies to food / medication List: _____
Surgery: Age ____ Describe _____
Is the child up to date on immunizations? Yes No, Why not? _____

Doctors seen: (circle all that apply)
Pediatrician Date of last visit ____ Diagnosis_____
Developmental Pediatrician Date _____ Diagnosis_____
Neurologist Date _____ Diagnosis_____
Suspected seizures? No Yes, Describe: _____
Seizures diagnosed, type: _____
Genetics Date_____ Diagnosis_____
Psychiatry Date_____ Diagnosis_____
Gastroenterology Date_____ Diagnosis_____
Stomach / intestinal problems, type:_____
Endocrinology Date_____ Diagnosis_____

Diagnostic Testing (circle all that apply)

EEG (brain wave test)	Date_____	Results:_____
MRI	Date_____	Results:_____
CT Scan	Date_____	Results:_____
Opthamology Evaluation	Date_____	Results:_____
Chromosomal / DNA testing	Date_____	Results:_____

Other, describe: _____

Medication History

Please list medications your child currently takes:

Name of Medication	Dose & Frequency	Date Started	Reason	Effectiveness

Who prescribes the medications? _____
Phone Number:_____
How often does he or she see the child:_____
Date of last visit: _____

Please list additional medications your child has taken in the past:

Name of Medication	Dose & Frequency	Date Started & Ended	Reason	Effectiveness

Who prescribed the past medications? _____

Family History

Have any members of the biological mother's or father's families had any of the following problems or disorders (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	Mental Retardation	Speech / language delay
Autism / PDD	Tics / Tourette's syndrome	Other learning disability
Reading problem	Emotional disturbance / mental illness	Bipolar / manic-depressive disorder
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 Level: _____ Type of class: Regular Special

Current # of: Students ____ Teachers ____ Aides ____ Does your child have a 1:1 Aide? Yes No

Please list all of the schools, including preschools, your child has attended. For preschools, please indicate the days per week and hours per day of attendance:

Name of School Age / Grade attended

_____
_____
_____
_____
_____
_____
_____

Is your child on an IEP (Individual Education Plan)? Yes No
What is the eligibility condition (e.g. Autism, Speech / Language Impairment, etc.)? _____

SERVICES

Please indicate the services your child currently receives:

School District

Service	Sessions per week	Length per session
Speech Therapy:		
Occupational Therapy:		
Physical Therapy:		
Adaptive Physical Education:		
Discrete Trial / ABA:		
Social Skills:		
Other:		

Private Services
Please indicate the services that are paid for privately or through an insurance company:

Service	Provider	Sessions per week	Length per session
Speech Therapy:			
Occupational Therapy:			
Physical Therapy:			
Adaptive Physical Education:			
Discrete Trial / ABA:			

Social Skills:

Other:

Regional Center
Is your child currently a client of Regional Center? Yes No
Which Regional Center? _____ Eligibility Category: _____

Please indicate services you and your child currently receive from Regional Center:

Service	Provider	Sessions per week	Length per session
Respite:			
Discrete Trial / ABA:			
Social Skills:			
Other:			

Please Note: If your child has seen a psychologist at any time in the last year for testing or treatment, please be sure to advise the doctor.

ADDITIONAL COMMENTS: Please note below any further information you feel may be helpful in the evaluation of your child

_____
_____
_____
_____
_____
_____
_____

_____ _____
Parent or Guardian's Signature Date

THANK YOU FOR TAKING THE TIME TO CAREFULLY COMPLETE THIS QUESTIONNAIRE.