

Child History Form

Please provide information to the best of your knowledge. If some questions are not applicable to you or your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet. All information is confidential. Although lengthy, the information that you provide on this form will help me gain a better understanding of your child and help me best assist you. Thank you for taking the time to complete it.

GENERAL INFORMATION:

Child's name: _____ Today's Date: _____
First Middle Last

Gender of child: Male Female Birth date of child: _____ Age: _____

Child lives at: _____
Number and Street City, State, Zip

Home Phone: _____ Alternate Phone: _____

Email Address: _____

Form completed by: _____ Relationship to child: _____

REFERRAL INFORMATION:

Current Pediatrician or Family Doctor:

Name: _____

Telephone: _____ Fax: _____

****If you DO NOT want me to send a copy of the report to this physician, please mark here.**

Who referred you to (how did you hear about) Main Line Neuropsychology, PLLC? _____

CURRENT CONCERNS:

What are your current concerns and how long have they been a concern?

What type of services are you seeking?

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PRENATAL AND POSTNATAL HISTORY:

PRE-NATAL HISTORY:

Please answer which of the following conditions may have occurred during this pregnancy and explain (month, amount, treatment, etc.) in the space below:

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Edema (swelling of the hands and feet) | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy (Seizure) |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal bleeding (when? _____) | <input type="checkbox"/> | <input type="checkbox"/> | Infections (colds, flu, urinary tract) |
| <input type="checkbox"/> | <input type="checkbox"/> | Toxemia | <input type="checkbox"/> | <input type="checkbox"/> | Other illnesses |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional stress | <input type="checkbox"/> | <input type="checkbox"/> | Cigarettes used (average #/Day) |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol used |
| <input type="checkbox"/> | <input type="checkbox"/> | X-ray studies | <input type="checkbox"/> | <input type="checkbox"/> | Marijuana used |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospitalization | <input type="checkbox"/> | <input type="checkbox"/> | Cocaine used |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever | <input type="checkbox"/> | <input type="checkbox"/> | Other drugs used |
| <input type="checkbox"/> | <input type="checkbox"/> | Operations (specify below) | <input type="checkbox"/> | <input type="checkbox"/> | Injuries |
| <input type="checkbox"/> | <input type="checkbox"/> | Medications used (specify below) | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Preterm labor | | | |

Please explain all "Yes" answers

BIRTH HISTORY:

Was the baby born on time? Yes No
 If No, was he/she Early or Late Length of pregnancy (weeks)? _____

Age of mother at birth: _____ Age of father at birth: _____

Weight of child at birth: _____ Type of delivery (please circle): C-Section or Vaginal

Please check the following conditions that may have occurred during delivery:

- Type of Labor Onset: Induced Spontaneous
- Type of Anesthesia: Gas Spinal Local
- Baby's Presentation: Breech Head Transverse (sideways)

Please check the following problems that may have occurred during labor:

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Toxemia/eclampsia | <input type="checkbox"/> | <input type="checkbox"/> | Fetal distress |
| <input type="checkbox"/> | <input type="checkbox"/> | Maternal fever | <input type="checkbox"/> | <input type="checkbox"/> | Medications used (please specify: _____) |

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CHILD'S POST DELIVERY PERIOD:

Check which of the following problems may have occurred after the child's birth and explain the amount and treatment in the space below.

- | | | | | | |
|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|------------------------------|
| Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble breathing | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice |
| <input type="checkbox"/> | <input type="checkbox"/> | Cord around the neck | <input type="checkbox"/> | <input type="checkbox"/> | Poor feeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Knot in cord | <input type="checkbox"/> | <input type="checkbox"/> | Required a blood transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Prolapsed cord | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting / reflux |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhage (bleeding) in head | <input type="checkbox"/> | <input type="checkbox"/> | Floppy muscle tone |
| <input type="checkbox"/> | <input type="checkbox"/> | Hydrocephalus (water on the brain) | <input type="checkbox"/> | <input type="checkbox"/> | Incubator care |
| <input type="checkbox"/> | <input type="checkbox"/> | Cyanosis (turned blue) | <input type="checkbox"/> | <input type="checkbox"/> | Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Need for ventilation | <input type="checkbox"/> | <input type="checkbox"/> | Fever |

Please explain all "Yes" answers:

Number of days infant stayed in the hospital after delivery: _____

Apgar Scores (if known): 1 minute _____ 5 minutes _____ 10 minutes _____

INFANCY:

Were any of the following present in your baby to a significant degree during the first few years of life? If so, please describe:

- | | | | | | |
|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|--------------------------------|
| Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty feeding | <input type="checkbox"/> | <input type="checkbox"/> | Extremely passive |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive irritability | <input type="checkbox"/> | <input type="checkbox"/> | Frequent head banging |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty comforting | <input type="checkbox"/> | <input type="checkbox"/> | Excessive restlessness |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty sleeping | <input type="checkbox"/> | <input type="checkbox"/> | Always had to be held |
| <input type="checkbox"/> | <input type="checkbox"/> | Did not like to cuddle | <input type="checkbox"/> | <input type="checkbox"/> | Significant separation anxiety |

Please explain all Yes answers:

HEALTH HISTORY:

MEDICATION HISTORY:

Does your child take medication? Yes No

Medication	Dosage	Frequency	Start date – End date	Reason for discontinuing

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MEDICAL HISTORY:

Please check which of the following your child has had and note the age, any complications, and frequency below:

- | | | | | | |
|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|----------------------------------|
| Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospitalizations | <input type="checkbox"/> | <input type="checkbox"/> | Vision problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgery | <input type="checkbox"/> | <input type="checkbox"/> | Hearing problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Trauma (stitches / broken bones) | <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Head trauma | <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of consciousness | <input type="checkbox"/> | <input type="checkbox"/> | Stomach aches |
| <input type="checkbox"/> | <input type="checkbox"/> | Coma | <input type="checkbox"/> | <input type="checkbox"/> | Excessive vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Pica (eating nonfood items) |
| <input type="checkbox"/> | <input type="checkbox"/> | Tics | <input type="checkbox"/> | <input type="checkbox"/> | Sleep problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Staring spells | <input type="checkbox"/> | <input type="checkbox"/> | Bed wetting |
| <input type="checkbox"/> | <input type="checkbox"/> | Tremor | <input type="checkbox"/> | <input type="checkbox"/> | Stool soiling |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor muscle tone | <input type="checkbox"/> | <input type="checkbox"/> | Bowel problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Falls frequently | <input type="checkbox"/> | <input type="checkbox"/> | Ear infections (how many?) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Other infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Persistent high fever | <input type="checkbox"/> | <input type="checkbox"/> | Accidental poisoning |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Other medical problems |

Please explain all Yes answers:

Please check Yes/No for the following tests/labs your child may have had:

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Brain Scan (CT/MRI): Date: _____ Results: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Lab Test (EEG): Date: _____ Results: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Genetic/Chromosome Test: Date: _____ Results: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____: Date: _____ Results: _____ |

SERVICES / INTERVENTION:

Has your child previously or does he/she currently participate in any of the following?:

	Frequency: (e.g., times/week)	Duration:	Beginning/Ending Dates:	Where:
Speech & Language Therapy				
Occupational Therapy				
Physical Therapy				
Psychotherapy				
Psychiatric Care				
Neurologic Exam				
Other:				

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DEVELOPMENTAL MILESTONES:

Please list the age at which your child accomplished the following developmental milestones. If you feel the milestone is not appropriate yet for the age of your child, please write N/A.

<u>Milestone:</u>	<u>Age Milestone Accomplished</u>	<u>Do you feel it was met On-Time, Early, or Late?</u>		
Smiled in response (social smile)	_____	<input type="checkbox"/> On-Time	<input type="checkbox"/> Early	<input type="checkbox"/> Late
Sat independently	_____	<input type="checkbox"/> On-Time	<input type="checkbox"/> Early	<input type="checkbox"/> Late
Crawled independently	_____	<input type="checkbox"/> On-Time	<input type="checkbox"/> Early	<input type="checkbox"/> Late
Walked independently	_____	<input type="checkbox"/> On-Time	<input type="checkbox"/> Early	<input type="checkbox"/> Late
Said "mama" or "dada" specifically	_____	<input type="checkbox"/> On-Time	<input type="checkbox"/> Early	<input type="checkbox"/> Late
Said 1 st word other than "mama" or "dada"	_____	<input type="checkbox"/> On-Time	<input type="checkbox"/> Early	<input type="checkbox"/> Late
Put two words together	_____	<input type="checkbox"/> On-Time	<input type="checkbox"/> Early	<input type="checkbox"/> Late
Put 4 to 5 sentences together to relate an experience	_____	<input type="checkbox"/> On-Time	<input type="checkbox"/> Early	<input type="checkbox"/> Late
You understood 100% of what your child said	_____	<input type="checkbox"/> On-Time	<input type="checkbox"/> Early	<input type="checkbox"/> Late
Knew primary colors	_____	<input type="checkbox"/> On-Time	<input type="checkbox"/> Early	<input type="checkbox"/> Late
Said the letters of the alphabet	_____	<input type="checkbox"/> On-Time	<input type="checkbox"/> Early	<input type="checkbox"/> Late
Printed first and last name	_____	<input type="checkbox"/> On-Time	<input type="checkbox"/> Early	<input type="checkbox"/> Late
Tied shoes	_____	<input type="checkbox"/> On-Time	<input type="checkbox"/> Early	<input type="checkbox"/> Late
Snapped, zipped, buttoned clothing	_____	<input type="checkbox"/> On-Time	<input type="checkbox"/> Early	<input type="checkbox"/> Late
Began to read	_____	<input type="checkbox"/> On-Time	<input type="checkbox"/> Early	<input type="checkbox"/> Late
Toilet trained (urine)	_____	<input type="checkbox"/> On-Time	<input type="checkbox"/> Early	<input type="checkbox"/> Late
Toilet trained (bowel)	_____	<input type="checkbox"/> On-Time	<input type="checkbox"/> Early	<input type="checkbox"/> Late

What language(s) is most often spoken in the home?: _____

Does your child speak and/or understand any language other than English?: _____

FAMILY HISTORY:

Marital Status of Parents:

Married for _____ years Never married Separated Divorced Widowed

**** If parents are divorced, who has primary conservatorship of this child (who has the right to consent to psychological services)?**

**** Please attach a copy of the divorce decree.**

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BEHAVIOR, DISCIPLINE, AND EMOTIONAL:

Please describe briefly any behavioral problems at school: _____

Please describe briefly any behavioral problems at home: _____

Describe your child's typical mood (e.g., happy, sad): _____

Types of discipline you use with your child:

- | | |
|---|---|
| <input type="checkbox"/> Rewards | <input type="checkbox"/> Verbal reprimands / verbal demands |
| <input type="checkbox"/> Time out (isolation) | <input type="checkbox"/> Removal of privileges |
| <input type="checkbox"/> Ignoring behavior | <input type="checkbox"/> Physical punishment |
| <input type="checkbox"/> Giving in to child | <input type="checkbox"/> Other (please specify) _____ |

Which form(s) of discipline has proven most effective? _____

Does your child currently (within the past 6 months) display any of the following behaviors frequently or intensively? (please check)

<input type="checkbox"/> Fainting, falling	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Low frustration tolerance	<input type="checkbox"/> Physical aggression
<input type="checkbox"/> Clumsiness	<input type="checkbox"/> Unusual fears	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Stealing
<input type="checkbox"/> Shy, timid	<input type="checkbox"/> Avoidance	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Use of profanity
<input type="checkbox"/> Social Isolation	<input type="checkbox"/> Laziness	<input type="checkbox"/> Attention seeking	<input type="checkbox"/> Skipping school
<input type="checkbox"/> Lack of confidence	<input type="checkbox"/> Obsessive-compulsive behaviors	<input type="checkbox"/> Irritability	<input type="checkbox"/> Fire setting
<input type="checkbox"/> Low self-esteem	<input type="checkbox"/> Stereotyped/repetitive behaviors	<input type="checkbox"/> Temper tantrums	<input type="checkbox"/> Destructiveness
<input type="checkbox"/> Crying episodes	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Oppositional behavior	<input type="checkbox"/> Cruelty to animals
<input type="checkbox"/> Unhappiness	<input type="checkbox"/> Poor concentration	<input type="checkbox"/> Noncompliance	<input type="checkbox"/> Gang Involvement
<input type="checkbox"/> Concern with weight	<input type="checkbox"/> Short attention span	<input type="checkbox"/> Defiance	<input type="checkbox"/> Cigarette use
<input type="checkbox"/> Sleep problems	<input type="checkbox"/> Distractibility	<input type="checkbox"/> Lying	<input type="checkbox"/> Alcohol / Substance use
<input type="checkbox"/> Other: _____			

Please provide additional information about any of the above you feel would be helpful: _____

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Please check the following based on your child's current behaviors (*Check current concerns, but explain below if the behavior was a concern in the past.):

Is your child sensitive to any of the following?: Sound, Light, Touch, Smell

Does your child have difficulty with transitions? Yes No

Does your child cry easily? Yes No

Is your child clingy? Yes No

Does your child have frequent temper tantrums? Yes No

Is your child affectionate? Yes No

Is your child aggressive? Yes No

Does your child talk obsessively about certain topics? Yes No; Which topic? _____

Do you feel your child speaks too loudly? Yes No

Does your child exhibit an odd prosody (i.e., rhythm, intonation) to his/her speech? Yes No

Does your child speak in overly formal (pedantic) language for his/her age? Yes No

Does your child exhibit good eye contact? Yes No

Does your child exhibit any restricted interests that appear abnormal in intensity? Yes No; What type? _____

Does your child exhibit any repetitive motor mannerisms (e.g., hand or finger flapping)? Yes No; What type? _____

Does your child exhibit any tic-like behavior? Yes No

Does your child prefer to play by himself/herself instead of with others? Yes No

Does your child exhibit a persistent preoccupation with parts of objects? Yes No

Does your child exhibit inflexible adherence to nonfunctional routines or rituals? Yes No

Does/Did your child engage in pretend play? Yes No

Does/Did your child show/point/bring objects to you? Yes No

Please provide additional information about any of the above that you feel would be helpful: _____

PERSONAL/SOCIAL:

What are your child's main hobbies and interests? _____

What about your child are you most proud of? _____

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What does your child enjoy doing most? _____

What does your child dislike doing most? _____

How many close friends does your child have? _____

Does your child have a best friend? Yes No If Yes, how old is he or she? _____

How easily does your child make friends? Worse than average Average Better than average

How well does your child get along with friends? Worse than average Average Better than average

If worse than average, please explain: _____

Does your child get along best with: Older children Children of the same age Younger children

EDUCATIONAL HISTORY:

Has your child received Early Intervention Services? Yes No

Has your child received Head Start Services? Yes No

Has your child received Preschool Special Education Services? Yes No

Has your child had an Individual Education Program (IEP)? Yes No

Has your child received 504 Accommodations? Yes No

Did your child attend preschool? Yes No If yes, at what age? _____

Name of preschool: _____

Were there any adjustment problems in preschool? Yes No

Were you concerned about your child's ability to succeed in preschool? Yes No

Name of child's current school: _____

School district: _____

Address of school: _____

Telephone: _____ Grade: _____ Teacher: _____

Current class placement: Regular Ed Special Ed Advanced/Gifted
 Bilingual English as a Second Language (ESL) Deaf-Ed Classroom

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Has cognitive or academic/achievement testing been completed by the school or by a private provider (e.g., neuropsychologist, psychologist)? Yes No Date: _____

**** If yes, please attach a copy of the evaluation.**

Is your child Often Seldom Never absent from school?

Usual reason for absence _____

Has your child ever been retained? Yes No What grade? _____ Why? _____

Briefly describe you child's current academic difficulties (if any): _____

When was the problem first noticed? _____

At what level do you feel your child is functioning academically compared to other children his/her age? _____

Has your child ever been:

Suspended from school Number of Suspensions: _____

Expelled from school Number of Expulsions: _____

Has your child ever been in any of the following educational programs, and if so, how long?

	Age(s) or Dates of Placement	Frequency of Intervention
<input type="checkbox"/> Gifted and Talented	_____	_____
<input type="checkbox"/> Section 504 services	_____	_____
<input type="checkbox"/> Content Mastery	_____	_____
<input type="checkbox"/> Resource Room Services	_____	_____
<input type="checkbox"/> Self-Contained Class	_____	_____
<input type="checkbox"/> Life Skills Class	_____	_____
<input type="checkbox"/> Behavioral/Emotional Disorders Class	_____	_____
<input type="checkbox"/> Counseling	_____	_____

Have any instructional modifications been attempted?

- | | |
|---|---|
| <input type="checkbox"/> Preferential seating | <input type="checkbox"/> Additional instructions |
| <input type="checkbox"/> FM system | <input type="checkbox"/> Peer teaching |
| <input type="checkbox"/> Increased positive feedback | <input type="checkbox"/> Reduced paper and pencil work |
| <input type="checkbox"/> Manipulatives in math | <input type="checkbox"/> Repeated review |
| <input type="checkbox"/> Extended time to complete assignments | <input type="checkbox"/> Outlines |
| <input type="checkbox"/> Shortened or modified assignments | <input type="checkbox"/> Positive reinforcers |
| <input type="checkbox"/> Study Sheets | <input type="checkbox"/> Behavior check cards / charts |
| <input type="checkbox"/> Control of distractions | <input type="checkbox"/> Predictable routines and classroom rules |
| <input type="checkbox"/> Behavior modification program | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Technologic assistance (word processor, calculator, augmentative communication device, etc.) | |

