Today's Date________________

PATIENT HEALTH AND DEVELOPMENTAL HISTORY

Name: ____ DOB: ________/________/__________

Age: ___________ Grade: ___________________ Birthplace: ____

Address: ____

City: __________________________ Zip: _______________ Home Phone: (______)_________________________

School: ____ City/District: ______________________________

Teacher(s): ____

Where did the recommendation for an evaluation come from? (Please be specific, include names and titles)

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Please explain the concerns that have lead you to have your child evaluated.

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Background History

1. Pregnancy

Is your child: ☐ Biological ☐ Adopted

Mother's age at time of pregnancy: _____________ Prenatal care began at __________ month

Duration of Pregnancy: Number of weeks __________ ☐ Full Term ☐ Premature

Number of previous pregnancies? ____________ Number of previous miscarriages? _____________

- ☐ Medications used during pregnancy: (please list) _____________________________________
- ☐ Alcohol consumed during pregnancy: Frequency? ____________________________________
- ☐ Tobacco used during pregnancy: Frequency? ____
- ☐ Other medications/drugs used during pregnancy:

Type	Frequency	Prescription
___________________________________	______________________	Yes No
___________________________________	______________________	Yes No
___________________________________	______________________	Yes No

Pregnancy Complications (please check all that apply):

- ☐ Toxemia
- ☐ Measles
- ☐ Abnormal Weight Gain
- ☐ Anemia
- ☐ Infections
- ☐ High Blood Pressure
- ☐ Excessive Swelling
- ☐ Vaginal Bleeding
- ☐ Excessive Vomiting
- ☐ Other _______________________________

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2. Client's Birth History

Birth Weight: ___________lbs. ____________oz. Length of Labor: _____________ hours

Child's condition at birth: ____

Complications that occurred during birth: (please check)

- ☐ Forceps used
- ☐ Labor induced
- ☐ C-Section
- ☐ Other complications: Please describe: ____

____

Incubator: how long? ____

Jaundiced: Bilirubin lights? Yes No If yes, how long? ____

Breathing problems right after birth: (please describe) ____

Length of stay in hospital: Mother ______________days Child ________________days

3. Development

At what age did your child first do the following?

Crawl: ______________________ Speak in single words: _________________________

Walk: _______________________ Speak in sentences: ___________________________

At what age was your child toilet trained? Day ___________ Night ___________

Has your child experienced any of the following problems? If yes, please describe:

- ☐ Walking difficulty ____
- ☐ Unclear speech ____
- ☐ Speech delays ____
- ☐ Feeding problems ____
- ☐ Bedwetting ____

- ❑ Soiling ______________________________
- ❑ Eating/Weight Problems ______________________________
- ❑ Difficulty learning to ride a bike ______________________________
- ❑ Difficulty learning to skip ______________________________
- ❑ Difficulty learning to throw or catch ______________________________

4. Medical History

Has your child experienced any of the following medical conditions? If yes, please describe:

- ❑ Sustained High Fever ______________________________
- ❑ Convulsions/Seizures ______________________________
- ❑ Coma or loss of consciousness ______________________________
- ❑ Head Injury ______________________________
- ❑ Heart Problems ______________________________
- ❑ Stomach Aches/Pains ______________________________
- ❑ Muscle Pain/Problems ______________________________
- ❑ Allergies/Asthma ______________________________
- ❑ Hearing Loss ______________________________
- ❑ Ear Infections/Tubes ______________________________
- ❑ Vision Problems ______________________________
- ❑ Urinary/Bladder Problems ______________________________
- ❑ ADHD (Please note if medicated) ______________________________

Has your child had any operations or serious illnesses? *Please describe & list age at time of illness.*

Illness/Operation	Age
______________________________	________
______________________________	________
______________________________	________

Please list <u>ALL medications</u> that your child is currently taking. *Include **purpose** & **dosage** of each*.

Medication and Purpose	Dose and Frequency
______________________________	____________
______________________________	____________
______________________________	____________

Date of most recent physical: ____________ Date of most recent hearing exam: ____________

Date of most recent vision exam: ____________ Use of Glasses or Contacts? Yes No

Name and phone number of pediatrician: ______________________________

Name and phone of psychiatrist: ______________________________

Name and phone number of psychologist: ______________________________

Name and phone number of other specialists who have seen you child: ______________________________

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5. Socio-Cultural History

Mother's name: ______________________________ Stepmother: Yes No

Address: ______________________________

Home Phone: (_____)____________ Work: (_____)____________, Ext.________ Mobile: (_____)____________

Occupation: ______________________________ Level of Education Completed: ____________

Maternal Family History of Educational/Mental/Medical Conditions (*list relationship to <u>client</u> & condition*)

____

Father's Name: ____ Stepfather: Yes No

Address: ____

Home Phone: (_____)____________ Work: (_____)_____________, Ext._______ Mobile: (_____)_____________

Occupation: _______________________________________ Level of Education Completed: ____________________

Paternal Family History of Educational/Mental/Medical Conditions (*list relationship to client & condition*)

____

____

With whom does your child live? ____

If parents are separated, who has custody of this child? ____

How often does the parent without full custody see this child? (*Please indicate.*)

- ❑ Once or more/week
- ❑ Once or twice/month
- ❑ Occasionally during the year
- ❑ Never

Does your child have other parent/guardian(s) or stepparents? Yes No (*If yes, please answer the following*)

Name: ______________________________________ Relationship to Child: ________________________________

Name: ______________________________________ Relationship to Child: ________________________________

Has your child ever experienced any parental separations, divorces, or death? (*circle one*) Yes No

If yes, when? __________________________ How old was your child at the time? __________________________

Please describe the circumstances: ____

____

Please list all languages spoken in the home: (Primary) ____

(Other) ____

Please list all siblings and any other children living at home.

Name	Age & Sex	Relationship to Child	Living in Home?
__________________________	_______ _______	_________________________	Yes No
__________________________	_______ _______	_________________________	Yes No
__________________________	_______ _______	_________________________	Yes No

Please indicate any existing Educational, Mental or Medical conditions for the siblings listed above:

____

____

6. Educational History

Please indicate whether your child has had any of the following school experiences:

- ❑ Preschool — If yes, where, what age & how long? ____________________________
- ❑ Retained a grade — If yes, when & why? ____________________________________
- ❑ Skipped a grade — If yes, when & why? ____________________________________
- ❑ Reading difficulty — If yes, describe. ____________________________________
- ❑ Math difficulty — If yes, describe. ____________________________________
- ❑ Poor grades — If yes, describe. ____________________________________
- ❑ Special Classes — If yes, when & why? ____________________________________
- ❑ Speech Therapy — If yes, describe. ____________________________________
- ❑ Occupational Therapy — If yes, describe. ____________________________________
- ❑ Special testing — If yes, when & why? ____________________________________
- ❑ Frequent school changes — If yes, describe. ____________________________________
- ❑ Frequent absences — If yes, describe. ____________________________________

Please list all schools that your child has attended since preschool:

Schools Attended	Dates and Grades
______________________________	______________________
______________________________	______________________
______________________________	______________________
______________________________	______________________

What is your child's present attitude towards school: ______________________________

____

7. Social Emotional Development

Personality/Behavioral Characteristics *Please check all that apply:*

- ❑ Easily Over-stimulated
- ❑ Short Attention Span
- ❑ Anxious
- ❑ Impulsive
- ❑ Fearful
- ❑ Easily frustrated
- ❑ Sensitive
- ❑ Destructive
- ❑ Friendly
- ❑ Aggressive
- ❑ Prefers To Play Alone
- ❑ Follower
- ❑ Daydreamer
- ❑ Loner
- ❑ Trusting
- ❑ Cooperative
- ❑ Shy
- ❑ Eager To learn
- ❑ Obedient
- ❑ Outgoing
- ❑ Repetitive
- ❑ Sucks Thumb
- ❑ Low energy
- ❑ Frequent fighting
- ❑ Distractible
- ❑ Leader
- ❑ Temper Tantrums
- ❑ Dependable
- ❑ Affectionate
- ❑ Moody
- ❑ Sad
- ❑ Defiant
- ❑ Compassionate

Friendships – *Please describe how this child relates to other children:*

Has problems relating to or playing with peers? Yes No

If yes, please describe ____

____

Plays/Associates with a set group of friends Yes No

Is accepted by classmates/peers Yes No

Family Relationships – *Please describe how your child relates to family members:*

Relates well with family members? Yes No

If no, please describe ____

____

Please describe any significant family events or dynamics ______________________________

____

Activities/interests that your child does with family: (*check all that apply*)

- ❑ Movies
- ❑ Meals
- ❑ Trips
- ❑ Television
- ❑ Games
- ❑ Sports
- ❑ Travel/trips
- ❑ Other: _______

Please describe your child's strengths: ______________________________________

____

Please describe discipline used: ____

____

Parent Concerns:

Recent change in behavior/friends? Yes No

If yes, please describe ____

Sexual behaviors? Yes No

If yes, please describe ____

____

Self-inflicting wounds/suicide attempts? Yes No

If yes, please describe ____

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Difficulties with the law/authority? Yes No

If yes, please describe ____

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What are your goals for this testing experience?______________________________________

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Please provide any additional information you feel is relevant: ___________________________

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