Today's Date: ___________________________

CHILD/ADOLESCENT

PATIENT HEALTH AND DEVELOPMENTAL HISTORY

Client's Name: ____ DOB: ________/________/__________

Age: ______ Grade: _______________ Birthplace: ____

Parent 1 Name: ____________________________ Parent 2 Name: ___________________________________

Parent 1 Cell: ______________________________ Parent 2 Cell: _____________________________________

Parent 1 Email: ____________________________ Parent 2 Email: ___________________________________

Address: _______________________________________ City: _________________________ Zip: __________

School: ____ City/District: ______________________________

Teacher(s): ____

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

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

Background History

1. Pregnancy

Is your child: Biological Adopted – age of child at time you took custody__________________

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

Pregnancy Complications (please check all that apply):

Toxemia
Measles
Abnormal Weight Gain
Anemia
High Blood Pressure
Excessive Swelling
Vaginal Bleeding
Excessive Vomiting
Preterm Labor
Other ____________________________

2. Client's Birth History

Birth Weight: __________lbs. ___________oz. Length of Labor: ____________ hours

Child's condition at birth:

Delivery: Forceps used Labor induced C-Section

Complications: Please describe:

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
Language delays
Feeding problems
Bedwetting
Soiling
Gross Motor Delays
Fine Motor Delays

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
ADHD (Please note age diagnosed)
Anxiety (Please note age diagnosed)

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

Illness/Operation Age

Please list ALL medications 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 your child: Phone Number

5. Family History

Parent 1 Name: ____ Step-parent: Yes No

Address (if different from client): ____

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

Occupation: ____ Level of Education Completed: ___________________

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

Parent 2 Name: ____ Step-parent: Yes No

Address (if different from client): ____

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

Occupation: ______________________________________ Level of Education Completed: ___________________

Paternal Family History of Educational/Mental/Medical Conditions (*list relationship to* <u>*client*</u> *& 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? 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:

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 Other:

Please describe discipline used:

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. ____
Frequent school changes	If yes, describe. ____
Frequent absences	If yes, describe. ____
Special Classes	If yes, when & why? ____
Special testing	If yes, when & why? ____
Speech Therapy	If yes, describe. ____
Occupational Therapy	If yes, describe. ____
Vision Therapy	If yes, describe. ____

Has your child ever had or currently have an Individualized Education Program (IEP)? Yes No

If yes, please note dates, qualifying conditions, and frequency of services:

Does your child currently have a 504 Plan or any accommodations in school? Yes No

If yes, please note dates and accommodations provided:

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

Please describe your child's strengths:

Please describe your child's challenges:

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

Personality/Behavioral Characteristics
Please check all that apply:

Friendly	Leader	Moody	Short Attention Span
Trusting	Compassionate	Sad	Distractible
Cooperative	Affectionate	Withdrawn	Easily Over-Stimulated
Shy	Dependable	Sucks Thumb	Anxious
Eager To Learn	Creative	Repetitive	Impulsive
Obedient	Confident	Follower	Fearful
Outgoing	Takes Initiative	Low Self-Esteem	Easily Frustrated
Happy	Funny	Destructive	Over-Sensitive
Independent	Good Natured	Aggressive	Prefers To Play Alone
Curious	Easy-Going	Defiant	Loner
Patient	Athletic	Frequent Fighting	Low Energy
Kind	Clever	Temper Tantrums	Daydreamer
Intuitive	Talkative	Argumentative	Disorganized

Additional Parent Concerns:

Recent change in behavior/friends? Yes No If yes, please describe

Recent sexual behaviors? Yes No If yes, please describe

Self-inflicting wounds/suicide attempts? Yes No If yes, please describe

Difficulties with the law/authority? Yes No If yes, please describe

Please provide any additional information you feel is relevant: