Parent-Child Services Group, Inc.

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The READ Center

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ACADEMIC CHILD HISTORY FORM / UPDATE

Instructions to parents: *Please complete this form to the best of your knowledge and return it to the Center* ***promptly*** *in the enclosed envelope. If a question does not apply to your child, place N/A in the blank. If you need more space to answer a particular question, you may attach a separate sheet.*

Child's Name: ________________________________ Nickname:________________ Sex: ❒ M ❒ F

Birthdate: ____________________

Home Address: ____County: _________________

City: ______________________ State: __________________ Zip: ______________

Home Phone: (_____)______________

Does the child live with both parents? ______ Mother? ______________ Father? _____________

E-mail for Mother: _________________________ E-mail for Father: __________________________

Mother's Cell Phone: (_____)______________ Father's Cell Phone: (_____)______________

Mother's Name: ____________________________ Father's Name:______________________________

Mother's Employer: ______________________________ Phone: _____________________ Ext._______

Address: ____

City: _______________________________ State: _________________ Zip: _______________

Father's Employer: ______________________________ Phone: _____________________ Ext._______

Address: ____

City: ________________________________ State: _________________ Zip: _______________

Pediatrician: ___________________________________ Phone: _________________________________

Address: ____

City: _______________________________ State: _________________ Zip: _______________

Insurance Company: ____ ID#:_______________________

Address: ____

City: _______________________________ State: _________________ Zip: _______________

Group Number: ____________________________Effective Date of Plan: _________________

Insurance Policy Holder: ______________________________Date of Birth: ___________

Insured's Social Security #: ____________________ Child's SS: ____________________

Name of Emergency Contact Person: _____________________________Phone:____________________

Name of Person Completing this Form: ____

Relationship to Child: _____________________________________ Date: ______________________

I. FAMILY HISTORY:

Father's Age: ________ Present Occupation: ______________________________

Education (highest level): ______________________________

Did he have any developmental delays, speech problems, or special learning problems?

❒ Yes ❒ No If Yes, please describe: ______________________________

____

Mother's Age: ________ Present Occupation: ______________________________

Education (highest level): ______________________________

Did she have any developmental delays, speech problems, or special learning problems?

❒ Yes ❒ No If Yes, please describe: ______________________________

____

Are the parents: Divorced? ❒ Separated? ❒ If divorced, what are the custody arrangements?
(Please attach a copy of the custody papers): ______________________________

____

Does the child see the non-custodial parent? ❒ Yes ❒ No If Yes, how often? ________

____

Comments: ______________________________

____

Names of Siblings	Full or half sibling?	Age	Sex	Developmental/Speech Problems?	School Performance?	Special Education?

Other persons living in the home:

Name	Age	Relation to Child

Comments: ______________________________

____

____

Do any relatives or persons in the immediate family have any of the following?

			If Yes, who?
Neurological Disease	Yes ❒	No ❒	________
Seizures (Epilepsy)	Yes ❒	No ❒	________

Hearing Problems Yes ❐ No ❐ ______
Visual Problems Yes ❐ No ❐ ______
Emotional Problems Yes ❐ No ❐ ______
Mental Retardation Yes ❐ No ❐ ______
Hyperactivity Yes ❐ No ❐ ______
Learning Problems Yes ❐ No ❐ ______
Similar Problems to Child Yes ❐ No ❐ ______
Does any disease run in the family? Yes ❐ No ❐ ______
What disease?______

II. BIRTH/DEVELOPMENTAL HISTORY:

Was the child adopted? Yes ❐ No ❐ If Yes, at what age? ______ From where?______

Were there any complications at birth that might impact on learning? ______

Does the child have any physical defects? ❐ Yes ❐ No If Yes, describe

Was the child's motor development: Average? ❐ Fast? ❐ Slow? ❐

Was the child's speech development: Average? ❐ Fast? ❐ Slow? ❐

III. MEDICAL/HEALTH INFORMATION:

Has the child ever had:

	Age	Severity	Hospitalized? When/Where?	Change in Development?
❐ Immunization reaction				
❐ Encephalitis				
❐ Meningitis				
❐ Fever of 104+				
❐ Allergies				
❐ Asthma				
❐ Running ears				
❐ Ear infections				
❐ Convulsions/seizures				

Describe any other serious illnesses, significant falls,injuries,or loss of consciousness:

Describe any surgery and resulting recommendations:______

Is the child currently on any medications? ❐ Yes ❐ No If Yes, what? (Name & dosage):

Have you consulted any medical specialist(s) for the child? ❐ Yes ❐ No If Yes:

Age? _____ Who? ______ Where: ______
Reason? ______
Results: ______

Age? ____ Who? ______________________ Where: ____________________________________
Reason? _______________________________________
Results: ____

Indicate any special recommendation(s) by the child's physician: _________________________
____
____
____

Allergies to foods/medications? ____
____

Special Diets? ____

IV. BEHAVIOR AND SOCIAL HISTORY:

Please check any if the following traits are characteristic of your child:

- ❒ Nervous?
- ❒ Well-behaved?
- ❒ Clumsy?
- ❒ Impulsive?
- ❒ Stubborn?
- ❒ Shy?
- ❒ Show-Off?
- ❒ Rude?
- ❒ Distractable?
- ❒ Destructive?
- ❒ Easily discouraged?
- ❒ Easily excitable?
- ❒ Selfish?
- ❒ Jealous?
- ❒ Poor eater?
- ❒ Picky eater?
- ❒ Slow to respond?
- ❒ Quick to respond?

Please check any of the following behaviors that your child exhibits:

- ❒ Wet the bed?
- ❒ Have temper tantrums?
- ❒ Refuse to obey?
- ❒ Run away when called?
- ❒ Whine frequently?
- ❒ Hurt pets?
- ❒ Drool?
- ❒ Hit, kick or bite others?
- ❒ Bang his/her head?
- ❒ Repeat the same act for an undue length of time?
- ❒ Have nightmares frequently?
  Number of times per week? ___ per month? ___
- ❒ Walk in his/her sleep?
  Number of times per week? ___ per month? ___
- ❒ Set fires?
- ❒ Suck his/her thumb?
- ❒ Steal?
- ❒ Lie?
- ❒ Fight with others?
- ❒ Prefer older children?
- ❒ Prefer younger children?
- ❒ Eat inedible objects?
- ❒ Have blank spells?
- ❒ Have toilet accidents during the daytime?

How long will the child pay attention to preferred activities (TV, games, etc.)?
❒ 20 min. ❒ 10 min. ❒ 5 min. ❒ Less

How long will the child pay attention to non-preferred activities?
❒ 20 min. ❒ 10 min. ❒ 5 min. ❒ Less
What are non-preferred activities? ____

Has the child had any traumatic or unusual experiences, such as accidents, severe illness, or frightening situations? ❒ Yes ❒ No If Yes, describe: ______________________________
____
____
____

Does the child have any strong fears or dislikes? ❒ Yes ❒ No If Yes, describe:__________
____
____
____

Are there significant conflicts (e.g., marital, child/parent, child/siblings)in the home?
❒ Yes ❒ No If Yes,describe:____
____

What are your child's strengths? ____
____

What are your child's weaknesses? ______________________________
____

V. MISCELLANEOUS:

Which hand does the child prefer? Right ❒ Left ❒ Switches back and forth? ❒
Age established? ______________________________
Preferred hand of the mother? __________ Father? __________ Siblings? __________

Are there languages other than English spoken in the home? ❒ Yes ❒ No If Yes, what language(s)? ______________________________

Does the child speak or understand other languages? ❒ Yes No ❒ If Yes, what languages?
____

Who can help the child with home learning activities? ______________________________

VI. CONCERN AND PREVIOUS EVALUATION:

Who was the first to express concern about the child? ______________________________
When? __________ Why? ______________________________

Has any change occurred since that time? ❒ Yes ❒ No If Yes, to what do you contribute that change? ______________________________
____

Has the child had emotional, adjustment, or behavioral problems? ❒ Yes ❒ No If Yes, describe: ______________________________

Has the child received any psychological or psychiatric treatment? ❒ Yes ❒ No If Yes,
When? ____________________ By whom? ______________________________
Place ______________________________

Have you consulted with anyone else for the current concerns? ❒ Yes ❒ No If Yes,
When? ____________________ By whom? ______________________________
Recommendations: ______________________________
____

Please list any previous evaluations/special tests:

	Agency/Professional/Results	Date
Developmental		
Speech/Language		
Psychological		
Hearing		
Vision		
EEG		
CAT Scan		
PET Scan		
MRI		
Other		
Other		

VII. SCHOOL HISTORY:

School Zone: ______________________________

School now attending: ______________________________

Address: ______________________________

Phone: (_____)________________________ Current Grade: ___________

Teacher's name: ____

(Please list subjects and teachers' names for older students.)

Is the child frequently absent? ❒ Yes ❒ No If Yes, why? ______________________________

Has the child ever failed a grade, been held back, or skipped a grade? ❒ Yes ❒ No
If Yes, when? ____

In addition to this history form, it would be helpful for us to have copies of the child's school records and any evaluation or therapy reports from school personnel or other agencies. You can fax these to our office at (865)584-6607, bring them with you to the first appointment, or we can request them with your permission.

Additional Comments/Primary Concerns/Prior Diagnoses:______________________________________

Interviewed by: ____ Date: ___________________