

Parent-Child Services Group, Inc.

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CHILD HISTORY FORM

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: _____

Child's Social Security #: _____

Insurance Policy Holder: _____ Date of Birth: _____

Name of Emergency Contact Person: _____ Phone: _____

Name of Person Completing this Form: _____

Relationship to Child: _____ Date: _____

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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?

- | | | | |
|----------------------|------------------------------|-----------------------------|-------|
| Neurological Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Seizures (Epilepsy) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Hearing Problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Visual Problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Emotional Problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Mental Retardation | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Hyperactivity | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |

If Yes, who?

Learning Problems Yes No _____
 Similar Problems to Child Yes No _____
 Does any disease run in the family? Yes No _____
 What disease? _____

II. BIRTH HISTORY:

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

Did the birth father or birth mother have a history of infertility? Yes No Describe: _____

When was the mother first aware of the pregnancy (how soon after conception)? _____

What month of pregnancy did the mother first visit a doctor? _____

Were there any miscarriages prior to this pregnancy? Yes No If Yes, when? _____

Did the mother have any of the following complications during this pregnancy? (Check those applicable.)

- | | | |
|--|--|---|
| Anemia <input type="checkbox"/> | High blood pressure <input type="checkbox"/> | X-Rays <input type="checkbox"/> |
| Kidney disease <input type="checkbox"/> | Heart disease <input type="checkbox"/> | Staining <input type="checkbox"/> |
| German measles <input type="checkbox"/> | Toxemia <input type="checkbox"/> | Virus <input type="checkbox"/> |
| Bleeding <input type="checkbox"/> | Vomiting <input type="checkbox"/> | Swollen Ankles <input type="checkbox"/> |
| Emotional Stress <input type="checkbox"/> | Nutritional disturbance <input type="checkbox"/> | CMV <input type="checkbox"/> |
| Rh or other blood incompatibility <input type="checkbox"/> | HIV <input type="checkbox"/> | |
| If Rh, date of Rhogam _____ | | |
| Potential miscarriage or early contractions <input type="checkbox"/> | Other <input type="checkbox"/> | |
| Accident or injury <input type="checkbox"/> | Describe: _____ | |

Chronic illness, such as diabetes, kidney infections, thyroid problems, etc.
Describe: _____

Other illnesses Describe: _____

Hospitalization Reason: _____
When? _____

Did the mother smoke and/or drink alcoholic beverages during this pregnancy? Yes No
If Yes, how much? _____

Which medications, if any, did the mother take during this pregnancy?
 Aspirin Cough medicine Prescription Drugs
 Antihistamines Other (Describe: _____

Where was the child born? Home Hospital Name of Hospital: _____
City _____ State _____ Doctor _____

How many hours from the first contraction to birth? _____

Was the baby: Early? Late? By how much? _____

Was the mother given medication during labor? Yes No If Yes, why was it given? _____

Was the mother under anesthesia during childbirth? Yes No If Yes, what kind? _____

Was labor induced? Yes No If Yes, why? _____
How? _____

Was the baby born head first? Yes No Don't know

Were forceps used? Yes No If Yes, why? _____

Did the mother have a C Section? Yes No If Yes, why? _____

Did the baby have any bruises? Yes No If Yes, where? _____

Did the baby have any birthmarks? Yes No If Yes, where? _____

Was this a multiple birth? Yes No If Yes, how many? _____

Did the baby have breathing problems? Yes No Don't know

Was the cord around the neck? Yes No Don't know

Did the baby cry quickly? Yes No Don't know

Was the baby's color normal? Yes No Don't know

What was the baby's Apgar score at 1 minute? _____ 5 minutes? _____

If the baby was yellow (jaundiced), did he/she receive:

Oxygen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How long?	_____
Transfusions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How many?	_____
Phototherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How long?	_____

Birth weight: _____ lbs. _____ oz.

Were there any physical defects? Yes No If Yes, describe _____

Were there any other complications before the baby went home? Yes No If Yes, describe: _____

Was the baby placed in an incubator or special crib? Yes No If Yes, how long? _____ Why? _____

How long after birth did the baby go home? _____

III. DEVELOPMENTAL HISTORY:

A. GENERAL:

Was the baby normally active? Yes No Describe: _____

Was the baby limp? Yes No Stiff? Yes No

Did the baby show unusual trembling? Yes No

Did the baby fail to grow normally? Yes No

Did the baby fail to gain weight? Yes No

Was the baby different in any way from brothers or sisters? Yes No If Yes, how: _____

B. MOTOR DEVELOPMENT:

How old was the child when he/she:

Sat alone? _____	Crawled? _____	Pulled to a stand? _____
Walked holding on _____	Walked without holding on? _____	
Was toilet trained for urination? _____	Bowels? _____	

Was the baby's motor development: Average? Fast? Slow?

C. SPEECH/LANGUAGE DEVELOPMENT:

How old was the child when he/she:

Babbled and cooed? _____ Noticed others talking? _____
Spoke first words? _____ What words other than Mama or Dada? _____

Combined 2 or 3 words? _____ Spoke first sentences? _____

Was the child's speech development average? Fast? Slow?

D. FEEDING DEVELOPMENT:

Was the baby: Breastfed? Bottle-fed?

Did the baby have a feeding problem(s)? Yes No If Yes, describe: _____

Was the baby colicky? Yes No If Yes, how long? _____

Did the baby require formula changes? Yes No If Yes, describe: _____

Did the baby have frequent vomiting? _____ Projectile vomiting? _____

Difficulty sucking as an infant? Yes No

Excessive loss of liquid during sucking? Yes No

Difficulty transitioning to pureed food? Yes No

Difficulty transitioning to solid food? Yes No

Difficulty chewing? Yes No

Difficulty swallowing? Yes No Frequent gagging? Yes No

Dislike of varied textures? Yes No Describe: _____

How old was the child when he/she:

Fed self w/spoon? _____ Drank from a cup? _____

Does the child have esophageal reflux? _____ If so, what medications are given?

What are the child's favorite foods? _____

IV. MEDICAL/HEALTH INFORMATION:

Has the child ever had:

	<u>Age</u>	<u>Severity</u>	<u>Hospitalized?</u> <u>When/Where?</u>	<u>Change in Development?</u>
<input type="checkbox"/> Immunization reaction	_____	_____	_____	_____
<input type="checkbox"/> Encephalitis	_____	_____	_____	_____
<input type="checkbox"/> Meningitis	_____	_____	_____	_____
<input type="checkbox"/> Fever of 104+	_____	_____	_____	_____
<input type="checkbox"/> Allergies	_____	_____	_____	_____
<input type="checkbox"/> Asthma	_____	_____	_____	_____
<input type="checkbox"/> Running ears	_____	_____	_____	_____
<input type="checkbox"/> Ear infections	_____	_____	_____	_____
<input type="checkbox"/> Convulsions/seizures	_____	_____	_____	_____

Describe any other serious illnesses: _____

Describe any falls or injuries: _____

Describe any loss of consciousness: _____

Describe any surgery and resulting recommendations: _____

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

Are there any restrictions to the child's activities? Yes No If Yes, describe: _____

Have you consulted any medical specialist(s) for the child? Yes No If Yes:
Age? _____ Who? _____ Where: _____
Reason? _____
Results: _____

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

Date of the last physical examination: _____
Physician: _____

Indicate the child's present health: Good Fair Poor

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

Allergies to foods/medications? _____

Special Diets? _____

V. BEHAVIOR AND SOCIAL HISTORY:

Please indicate which of these traits are characteristic:

Is the child:

- | | |
|--|--|
| <input type="checkbox"/> Nervous? | <input type="checkbox"/> Destructive? |
| <input type="checkbox"/> Well-behaved? | <input type="checkbox"/> Easily discouraged? |
| <input type="checkbox"/> Clumsy? | <input type="checkbox"/> Easily excitable? |
| <input type="checkbox"/> Impulsive? | <input type="checkbox"/> Selfish? |
| <input type="checkbox"/> Stubborn? | <input type="checkbox"/> Jealous? |
| <input type="checkbox"/> Shy? | <input type="checkbox"/> Poor eater? |
| <input type="checkbox"/> Show-Off? | <input type="checkbox"/> Picky eater? |
| <input type="checkbox"/> Rude? | <input type="checkbox"/> Slow to respond? |
| <input type="checkbox"/> Distractable? | <input type="checkbox"/> Quick to respond? |

Does the child:

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

undue length of time?

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? _____

How does the child interact with adults? Easily Average Reluctant

How does the child interact with children? Easily Average Reluctant

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 marital conflicts in the home? Yes No If Yes, describe: _____

Are there significant conflicts between the child and the parent(s)? Yes No If Yes, describe: _____

Are there significant conflicts between the siblings? Yes No If Yes, describe: _____

Do the parents agree on how to discipline the child? Yes No

Who disciplines and how? _____

What types of discipline are most effective? _____

What types of discipline are least effective? _____

Does the child demand attention from one parent in particular? _____

Generally, how does the child relate to the mother? _____

To the father? _____

What do you enjoy doing with the child? _____

What types of play/leisure activity does the child enjoy most (i.e., alone or with others? quiet or active?) _____

What are the child's favorite toys? _____

Describe what the child does on a typical day. _____

What time does the child go to bed? _____ Wake up? _____

Does the child share: a room? bed? If so, with whom? _____

What household rules do you have regarding:

Bedtime? _____

Making noise in the house? _____

Amount of time allowed to listen to the radio, records or television? _____

Play on the computer, play station Game Boy etc.? _____

Type of television the child watches? _____

Preferred computer games? _____

Play time? _____

Leaving the house by himself/herself? _____

How far? _____

Other rules? _____

What are your child's strengths? _____

What are your child's weaknesses? _____

VI. MISCELLANEOUS:

Which hand does the child prefer? Right Left Switches back and forth?

Age established? _____

Preferred hand of the mother? _____ Father? _____ Siblings? _____

How much does the child talk at home? Average None A few words

Gestures with words If gestures with words, is it: Constantly Average

Mainly uses gestures

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? _____

How well does the family understand the child's speech?

- Easily understood
- Understood if the listener knows the topic
- Words understood now and then
- Completely unintelligible
- Gestures understood

How well do other people understand the child's speech?

- Easily understood
- Understood if the listener knows the topic
- Words understood now and then
- Completely unintelligible
- Gestures understood

Describe the child's movements: Sluggish Active Constant motion Awkward

Who can help the child with home learning activities? _____

VII. 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: _____

Do you suspect a hearing problem? Yes No If Yes, why? _____

Do you suspect a vision problem? Yes No If Yes, why? _____

Please list any previous evaluations/special tests:

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

Have any of the following been used to describe the child?

	Do you Agree?	Current Services:
<input type="checkbox"/> Autistic/PDD/ASD	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Brain-Damaged	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Cerebral Palsied	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Mentally Retarded	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Gifted	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Developmentally Delayed	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

VIII. DAY CARE/SCHOOL HISTORY:

School Zone: _____

Day care/school now attending: _____

Address: _____

Phone: (_____) _____ Current Grade: _____

Teacher's name: _____
(Please list subjects and teachers' names for older students.)

How does the child feel about day care/school? _____

About his/her teacher? _____

Is the child frequently absent? Yes No If Yes, why? _____

Are there any problems with day care/school? Yes No If yes, what? _____

What has the day care/school said about the child's performance? _____

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 birth and medical records, day care/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: _____

