CHILDHOOD HISTORY FORM
PARENT DATA

Child's Name: _____ Grade: _____

Date of Birth: _____

Source of Data: _____ Mother _____ Father _____ Other Date: _____

Child is presently living with:

_____Birth Mother _____Birth Father _____ Stepmother _____Stepfather

_____Adoptive Mother _____Adoptive Father _____Foster Mother _____Foster Father

_____Other (Specify): _____

Briefly state your view of the main problem/difficulty for your child:

_____

_____

_____

_____

PARENTS:

Parent 1: _____ Relationship to child: _____

Occupation: _____ Business Phone: _____

Age: _____ Age at time patient was born: _____

School:

Highest Grade Completed: _____

Learning Problems: _____

Attention Problems: _____

Behavioral Problems: _____

Medical Problems: _____

Have any of your blood relatives experienced problems similar to those your child is experiencing? If so, describe:

_____

Parent 2: _____Relationship to child:_____

Occupation: _____ Business Phone: _____

Age: _____Age at time patient was born_____

School:

Highest Grade Completed: _____

Learning Problems: _____

Attention Problems: _____

Behavioral Problems: _____

Medical Problems: _____

Have any of your blood relatives experienced problems similar to those your child is experiencing? If so, describe:

_____

_____

_____

SIBLINGS:

	Name	**Age**	**Medical, Social, or School Problems**
1.			
2.			
3.			
4.			
5.			
6.			

PREGNANCY – *Complications*:

Excessive Vomiting: _____ Hospitalization Required: _____

Excessive Staining/blood loss: _____ Threatened Miscarriage: _____

Infections (specify): _____

Toxemia: _____ Operations: _____

Other Illness(es) (specify): _____

Smoking during pregnancy: _____ # Cigarettes per day: _____

Alcoholic consumption during pregnancy: _____

Describe if beyond an occasional drink: _____

Medications taken during pregnancy: _____

X-ray studies during pregnancy: _____

Duration of Pregnancy (weeks): _____

DELIVERY:

Type of Labor: Spontaneous: _____ Induced: _____ Duration (hrs) _____

Type of Delivery: Normal: _____ Breech: _____ Cesarean: _____

Complications: Cord around neck: _____ Hemorrhage: _____

Infant injured during delivery: _____ Other: _____

Birth Weight: _____

POST DELIVERY PERIOD:

Jaundice: _____ Cyanosis (turned blue): _____ Incubator Care: _____

Infection: _____

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

INFANCY PERIOD:

Were any of the following present – to a significant degree – during the first few years of life?

If so, describe:

Did not enjoy cuddling: _____

Was not calmed by being held or stroked: _____

Difficult to comfort: _____

Colic: _____ Excessive restlessness: _____

Excessive irritability: _____

Diminished sleep: _____

Frequent head banging: _____

Difficult nursing: _____

Constantly into everything: _____

MEDICAL HISTORY:

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information:

Childhood diseases (describe ages and any complications): _____

Operations: _____

Hospitalization for illness: _____

Head injuries: _____

Convulsions: _____ With Fever: _____ Without Fever_____

Coma: _____

Persistent high fever: _____

Eye problems: _____

Ear problems: _____

Allergies or Asthma: _____

Poisoning: _____

Sleep problems: _____

Appetite: _____

PRESENT MEDICAL STATUS:

Approximate Height: _____ Approximate Weight: _____

Present illnesses for which the child is being treated: _____

Medications child is taking on ongoing basis: _____

DEVELOPMENTAL MILESTONES:

If you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall exactly, check the item at right.

	Age	**Early**	**Normal**	**Late**
Smiled:				
Sat without support:				
Crawled:				
Stood without support:				

	Age	Early	Normal	Late
Walked without assistance:				
Spoke first words:				
Said phrases:				
Said sentences:				
Bladder trained, day:				
Bladder trained, night:				
Bowel trained, day:				
Bowel trained, night:				
Rode tricycle:				
Rode bicycle (without training wheels):				
Buttoned clothing:				
Tied shoelaces:				
Named colors:				
Named coins:				
Said alphabet in order:				
Began to read:				

COORDINATION:

Rate your child on the following skills:

Walking: _____

Running: _____

Throwing: _____

Catching: _____

Shoelace tying: _____

Buttoning: _____

Writing: _____

Athletic Abilities: _____

Excessive number of accidents compared to other children: _____

COMPREHENSION AND UNDERSTANDING:

Do you consider your child to understand directions and situations as well as other children his or her age? If not, why not?

_____

_____

_____

How would you rate your child's overall level of intelligence compared to other children:

Below Average: _____ Above Average: _____ Average: _____

SCHOOL HISTORY:

Were you concerned about your child's ability to succeed in kindergarten? If so, please explain:

_____

Rate your child's school experiences related to academic learning:

	Good	Average	Poor
Nursery School:			
Kindergarten:			
Current Grade:			

To the best of your knowledge, at what grade level is your child functioning:

Reading: _____ Spelling: _____ Arithmetic: _____

Has your child ever had to repeat a grade? If so, when? _____

Present class placement: Regular class: _____ Special Class (if so, specify): _____

_____

Kinds of special counseling or remedial work your child is currently receiving: _____

_____

Describe briefly any academic school problems: _____

_____

Rate your child's school experiences related to behavior:

	Good	**Average**	**Poor**
Nursery School:			
Kindergarten:			
Current Grade:			

Does your child's teacher describe any of the following as significant classroom problems?

Doesn't sit in his or her seat _____

Frequently gets up and walks around the classroom _____

Shouts out. Doesn't wait to be called on _____

Won't wait his or her turn _____

Doesn't cooperate well in group activities _____

Typically does better in a one-to-one relationship _____

Doesn't respect the rights of others _____

Doesn't pay attention during storytelling or show & tell _____

Describe briefly any other classroom behavioral problems _____

_____

_____

As best as you can recall, please use the following space to provide a general description of your child's school progress in each grade. Use the back of this form if extra space is needed. _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PEER RELATIONSHIPS:

Does your child seek friendships with peers? _____

Is your child sought by peers for friendship? _____

Does your child play with children primarily his or her own age? _____

Younger? _____ Older? _____

Describe briefly any problems your child may have with peers: _____

_____

_____

_____

INTERESTS AND ACCOMPLISHMENTS:

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

- What are your child's areas of greatest accomplishment?

- What does your child enjoy doing most?

- What does your child dislike doing most?

- What do you like about your child?

LIST NAMES AND ADDRESSES OF ANY OTHER PROFESSIONALS CONSULTED

(including family doctor):

1. _____
2. _____
3. _____
4. _____

ADDITIONAL REMARKS:

_____

_____

_____

_____

_____

_____

_____

_____

_____