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Children's History Form

Child's Name: _________________________________ Birthdate:_______________
Address: ____
Phone #: ______________________Referred By: ________________________________
Reason for Consultation: ____
____
____
Name of Person Filling Out This Form: ______________________________________
Relationship to Child: ________________________ Date: ________________________
Was This Child Adopted? _____________

Pregnancies: List all of birth mother's pregnancies, including this child. If it ended in a miscarriage, please state the length of pregnancy.

Year	Length of Pregnancy	Birth Weight	Sex Assigned at Birth	Chosen Gender

Pregnancy with this Child:

Planned Pregnancy? _______If yes, how long did it take to get pregnant? _________
Infertility? __________If so, describe nature and treatment: _____________________
____
____

	Parent #1	Parent #2
Reaction to Conception		

Prenatal Care? ____________________ Morning Sickness? ______________

If so, how long did it last? ______________________

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Medical Complications During Pregnancy (describe for mother and baby): _______
____
____
____
____
____

Worries/Stress/Fears During Pregnancy (describe for each parent): _____________
____
____
____
____

During Pregnancy, Did Birth Mother,
Take prescription medication? _____________ Use illicit drugs? ___________
Drink alcohol? ___________

<u>Child's Birth</u>

 # Of Weeks at Birth _____________ Vaginal or Caesarian Delivery: _____________
Where was Baby Born: ____________________________
Complications (explain): ____
____
____
____
____
Time in Hospital – Baby: ________________ Mother: ____________________

<u>Infancy:</u>

Describe Baby's Temperament (e.g., easy, content, demanding, cranky, etc.)
____
____
____

<u>Feeding-</u> Did Mother Choose to Breast Feed? _____________
If so, did it go well?_______________ Difficulties: _________________________

____

____

How long was the baby breast fed? ____________________________________

Colic: ______________ If yes, what ages did it start and stop _________________

How was baby calmed: ____

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Any other GI problems (e.g., reflux, food allergies, diarrhea, constipation, spitting up, vomiting)? ____

Transition to Solid Food – What age introduced? ___________________________

Difficulties? ____

Eating Difficulties- Describe (pickiness, allergies/sensitivities, preferences, cravings, weight gain/growth)

6 to 12 mos: ____

12-24 mos: ____

23-36 mos.____

36 mos. to present: ____

____

____

<u>Sleeping</u>- Describe sleep patterns (getting to sleep, nighttime awakenings, where sleep, night terrors, nightmares, etc.):

0 to 6 mos: ____

____

6 mos. to 12 mos.: ____

____

1 yr to 2 yrs:____

____

Present: ____

____

<u>Health Problems</u> (past and current):

____

____

____

____

____

Medical Specialists Consulted: _______________________________________

____
____

Medications (specify current/past):
____
____

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<u>Developmental Milestones</u> (# of months):
Sat Alone _____________ Stood Alone_________________ Crawled _________
Walked Alone_________ First Words_________________
2 Word Phrases_________

<u>Coordination</u> – Can Your Child Do the Following?:
Run___________ Climb__________ Use spoon to feed:_______ Use fork to spear_________ Scribble ___________ Draw___________ Hold pencil correctly___________ Use a Scissors_____________ Use Playground Equipment ____________ Play Sports (specify)____
____
Ride a tricycle, bike with training wheels, a 2-wheeler (specify)_________________

<u>Self Care</u> (can your child do the following):
Toilet Trained (specify urine, feces, overnight):_____________________________
Undress: __________________ Dress:_________________________________
Brush Teeth: _________________________
Buttons, Zippers, Snaps ________________________________

<u>Behavioral Issues</u> (describe):
Frustration Tolerance: ____
____

Activity Level: ____
____

Attention Span: ____
____

How does he/she/they respond to frustration, anger, disappointment:

Temper Tantrum/Meltdowns (frequency, intensity, duration):

<u>Sensory Issues</u> (cravings, sensitivities – describe):

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<u>School History</u>

Early Intervention: Age Started ________________ Reasons __________________

Services Received ____

Daycare/Preschool(s): Name ____
Age Started ________ Therapy Received ___________________________________
____ Problems ___________________

Daycare/Preschool(s): Name ____
Age Started ________ Therapy Received ___________________________________
Problems____

Elementary School(s): Name ____
Type of Classroom ________________ Therapy Received _______________________
Problems:____

Elementary School(s): Name ____
Type of Classroom _______________Therapy Received _________________________
Problems:____

Middle/High School(s): Name ____
Type of Classroom ______________ Therapy Received _________________________

Problems ____
____

Middle/High School(s): Name ____
Type of Classroom ____________ Therapy Received _______________________
Problems ____
____

Other Special Education Services: ______________________________________
____

Private Therapy (specify practitioner, onset and duration and reason for starting)

Psychotherapy: ____
____
____

Occupational/Physical Therapy: ____
____
____

Speech/Language Therapy: ____
____
____

Other Therapies: ____
____
____

Family History

Family Member (parents/sibs)	Age	Highest Educational Level	Occupation	Health

Mental Health, Drug/Alcohol, Developmental Problems in Family and Extended Family (Please specify relationship to child): ________________________________

____

____

____

____

____

Has either parent had individual or couples psychotherapy/counseling in the past?

____

Social:

How are the child's peer social skills?: ___________________________________

____

____

Does he/she/they have a best friend? _____________
A Group of Friends: ____________

Does the child have any special interests? _________________________________

____

Is he/she/they a member of any clubs, sports teams, or participate in extracurricular activities? ____

____

How are his/her/their relationships with siblings?