**Comprehensive Child History Form**

**General Information:**

Today’s Date:   /  /

mm/dd/yyyy

**Child’s legal name:**            

*First**Middle**Last*

Nickname:       Gender:  Male  Female

Date of Birth:   /  /     Age:       Grade:

mm/dd/yyyy

Religion:       Race/Ethnicity:

Language(s) spoken in home:

Address:

City:       State:    Zip:

Home Phone:   -   -     Work:   -   -

Cell Phone:    -   -     Other Phone:    -   -

Email Address(es):

**Name of person completing this form:**

Relationship to patient: Mother  Father Other:

Is this child adopted?  No  Yes (complete the Adopted Child History Form not this form)

**Parent Name:**                   *First**Middle**Last*

Date of Birth:   /  /     Highest Grade Completed:

mm/dd/yyyy

Occupation:       Employer:

**Parent Name:**                   *First**Middle**Last*

Date of Birth:   /  /     Highest Grade Completed:

mm/dd/yyyy

Occupation:       Employer:

**Marital status of parents:** married never married separated divorced widowed

**Additional caregiver(s):** None orName:

Relationship (nanny, grandparent, etc.):

How much time does this person spend with your child?

**Who lives in the Child’s household?**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Name:*** | ***Age:*** | ***Male / Female*** | ***Relationship to child:*** |
|  |  | M  F |  |
|  |  | M  F |  |
|  |  | M  F |  |
|  |  | M  F |  |
|  |  | M  F |  |

**Name of pediatrician or family doctor:**

Name:       Phone:    -   -

**Who referred your child to me?**

Name:       Phone:    -   -

**Please list any services your child is currently receiving (speech, occupational therapy, tutoring, etc.):**

**Current Concerns:**

**Please check the areas below that you have concerns about your child.**

|  |  |  |
| --- | --- | --- |
| clingy to parent | attention seeking | easily distracted |
| impulsivity | hyperactivity | avoidance |
| low frustration tolerance | noncompliance | overly shy |
| oppositional behavior | social isolation | anxiety |
| aggression | lying | stealing |
| difficulty with transition | obsessive/compulsive behaviors | cruelty to animals |
| sensitivity to environment | temper tantrums | cries easily |

Please explain checked boxes:

Describe any concerns not listed above:

When did you first notice these problems?

What do you hope to address by coming to see Dr. Forrester?

Note specific services (if any) you are seeking:

**Pre-Natal History:**

Was this child the product of a planned pregnancy?  Yes  No

Did either parent take medication or fertility drugs to become pregnant?

No  Yes, please list:

Were any medical procedures used to become pregnant with this child?

No  Yes, explain:

Has mother had any other pregnancies?

No  Yes, list dates:

Has mother experienced any miscarriages, abortions, or stillbirths?

No  Yes, list dates:

Were the parents married at the time this child was conceived:  Yes  No

Length of parents’ relationship at the time this child was conceived:

Are the parents currently together?  Yes  No

**Check Yes / No for the items below which may have occurred during pregnancy:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Yes*** | ***No*** |  | ***Yes*** | ***No*** |  |
|  |  | Edema (swelling) |  |  | Accidents / Injuries |
|  |  | Vaginal bleeding |  |  | Breathing difficulties |
|  |  | Toxemia |  |  | Alcohol used |
|  |  | Emotional stress |  |  | Cigarettes used |
|  |  | High blood pressure |  |  | Abnormal weight gain |
|  |  | Infections (cold, flu, urinary) |  |  | Pre-term labor |
|  |  | Fever |  |  | Hospitalization |
|  |  | Medication used |  |  | Diabetes |
|  |  | Operations/Surgeries |  |  | Other (explain below) |

Please explain all “yes” answers:

**Birth History:**

Where was the baby born? (city/state/country)

Was the baby born on time? Yes  No ( early or  late? By how many weeks?      )

Weight of child at birth:       Apgar scores (if known):

Age of mother at birth:       Age of father at birth:

Does either parent have children from other relationships?

No  Yes, please list names and ages of children and parent:

**Check all that apply:**

|  |  |  |
| --- | --- | --- |
| spontaneous labor | vaginal delivery | toxemia/eclampsia |
| induced labor | c-section (planned:  yes  no) | maternal fever |
| breech presentation | VBAC (vaginal birth after c-section) | fetal distress |
| medication used | natural birth | other (describe below) |

Please add any comments regarding the items noted above:

**Post-Delivery Period:**

How many days did the baby stay in the hospital after birth?

How many days did the mother stay in the hospital after delivery?

**Check Yes / No for the items which may have occurred during the days following the child’s birth:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Yes*** | ***No*** |  | ***Yes*** | ***No*** |  |
|  |  | Difficulty breathing |  |  | Infection |
|  |  | Need for ventilation |  |  | Jaundice |
|  |  | Blood transfusion |  |  | Poor feeding |
|  |  | Bleeding in head |  |  | Vomiting / Reflux |
|  |  | Water on the brain |  |  | Floppy muscle tone |
|  |  | Turned blue |  |  | Neonatal ICU (NICU) |
|  |  | Fever |  |  | Other (explain below) |

Please explain all “yes” answers:

**Development:**

Was your child breast-fed?

No  Yes, from age       until age

describe the circumstances around stopping:

describe the weaning process:

Was your child bottle-fed?

No  Yes, from age       until age

describe the circumstances around stopping:

describe the weaning process:

Did your child have colic?

No  Yes, from age       until age

Did your child experience any feeding problems?

No  Yes, describe:

Does your child experience any feeding problems now?

No  Yes, describe:

**Check items below which may have occurred during the first few years of life:**

|  |  |  |
| --- | --- | --- |
| difficult to comfort | excessive restlessness | extended crying |
| excessive irritability | sleep difficulties | extremely passive |
| always had to be held | frequent head banging | other (describe below) |

Please explain all “yes” answers:

**Please complete the chart below regarding your child’s accomplishment of early developmental milestones:**

|  |  |  |
| --- | --- | --- |
| ***Milestone*** | ***Age milestone accomplished*** | ***Did you feel this was:*** |
| Smiled (social smile) |  | On Time  Early  Late |
| Laughed |  | On Time  Early  Late |
| Rolled over |  | On Time  Early  Late |
| Sat independently |  | On Time  Early  Late |
| Crawled independently |  | On Time  Early  Late |
| Stood independently |  | On Time  Early  Late |
| Walked independently |  | On Time  Early  Late |
| Waved bye-bye |  | On Time  Early  Late |
| Toilet trained (urine) |  | On Time  Early  Late |
| Toilet trained (bowel) |  | On Time  Early  Late |
| Spoke first words |  | On Time  Early  Late |
| Put two words together |  | On Time  Early  Late |

What were your child’s first words?

Could you understand your child’s speech by age 2 years?  Yes  No

Could others understand your child’s speech by age 2 years?  Yes  No

Could your child speak in simple sentences by age 2 years?  Yes  No

How does your child typically communicate now?  gesture  words  sentences

What is your child’s sleeping arrangement?  Room alone  With sibling Parents room  Other

Where does your child sleep?  Crib  Bed  Parents bed  Other:

Is it difficult for your child to go to sleep?  No  Yes, describe:

How long does it take him/her to fall asleep?

Do you have a regular bedtime routine?  No  Yes, describe:

Does your child wake up during the night?  No  Yes (how many times?      )

How long does he/she stay awake?       What helps him/her go back to sleep?

Is your child a restless sleeper?  No  Yes, describe:

Does (Did) your child have a special object (blanket, teddy bear, etc.)?

No  Yes, describe:       Until age:

Does (Did) your child have any self-soothing behavior (e.g., suck thumb, pacifier, twirl hair, etc.)?

No  Yes, describe:       Until age:

How many hours of screen time (TV, video games, etc.) does your child have each day?

What are his/her favorites?

**Temperament:**

I would like to get a sense of how you would describe your child’s temperament. Please describe his/her temperament using adjectives below:

1)       2)       3)

**Check the type of discipline you use with your child:**

|  |  |  |
| --- | --- | --- |
| rewards | time out (isolation) | avoidance of child |
| verbal reprimands | removal of privileges | physical punishment |

Which form of discipline has proven most effective?

How often must you discipline your child?

What is the most common reason for discipline?

Does your child have any close friends?  No  Yes (how many?

Does your child get along well with his/her peers?  Yes  No, describe:

Does your child make new friends easily?  Yes  No, describe:

Does your child get along best with children that are:  same age  younger  older

Please add comments regarding your child’s peer relationships:

**Please check if your child is:**

|  |  |  |
| --- | --- | --- |
| loud and noisy | easily angered | able to entertain him/herself |
| sensitive to sound | shy with new adults | affectionate |
| sensitive to touch | shy with new children | aggressive |
| sensitive to light | physically cautious | sluggish/slow moving |
| sensitive to smell | a dangerous risk taker | overly active |

Please explain all checked boxes:

What are your child’s favorite activities?

What are your child’s least favorite activities?

Describe your child’s typical mood:

What about your child makes you most proud?

**Child’s Health History:**

**Check Yes / No for the items below which your child may have experienced**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Yes*** | ***No*** |  | ***Yes*** | ***No*** |  |
|  |  | Vision problems |  |  | Pica (eating nonfood items) |
|  |  | Hearing problems |  |  | Excessive vomiting |
|  |  | Asthma |  |  | Head trauma |
|  |  | Allergies |  |  | Loss of consciousness |
|  |  | Stomach aches |  |  | Coma |
|  |  | Sleep problems |  |  | Seizures |
|  |  | Bed-wetting |  |  | Tics |
|  |  | Stool soiling |  |  | Staring spells |
|  |  | Chronic ear infections |  |  | Tremor |
|  |  | Hospitalization |  |  | Frequent falls |
|  |  | Surgery |  |  | Anemia |
|  |  | Broken bones, stitches |  |  | Persistent high fever |
|  |  | Accidental poisoning |  |  | Headaches |
|  |  | Floppy muscle tone |  |  | Other problems (explain) |

Please explain all “yes” answers:

Do you have any particular concerns regarding your child’s physical health?

No  Yes, explain:

Does your child currently take medication?

No  Yes, list:

List any medications your child has taken in the past:

When was your child’s last physical exam?       Where?

**Please check if your child has had any of the following or  None**

|  |  |  |
| --- | --- | --- |
| Individual Psychotherapy | Group Psychotherapy | Occupational Therapy |
| Physical Therapy | Speech Therapy | Developmental Evaluation |
| Educational Evaluation | Brain scan (CT or MRI) | EEG testing |
| Genetic/Chromosome tests | Lead testing | Other (explain below) |

Please explain all checked boxes including dates, providers, and results:

**Family Health History:**

**Check Yes / No for each item below that may apply to a family member and then state relation (e.g., mother, brother, paternal uncle, maternal cousin, etc.)**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Yes*** | ***No*** |  | ***Relation to child:*** |
|  |  | Heart Disease |  |
|  |  | Cancer |  |
|  |  | Vision Problems |  |
|  |  | Hearing Problems |  |
|  |  | Epilepsy/Seizures |  |
|  |  | Birth Defects |  |
|  |  | Cerebral Palsy |  |
|  |  | Genetic Condition |  |
|  |  | Muscle/Motor Problem |  |
|  |  | Other (describe:      ) |  |

Please add any relevant details you feel are important regarding items above:

Are there any other health issues that run in the family?  No  Yes, explain:

**Family Emotional and Learning History:**

**Check Yes / No for each item below that may apply to a family member and then state relation (e.g., mother, brother, paternal uncle, maternal cousin, etc.)**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Yes*** | ***No*** |  | ***Relation to child:*** |
|  |  | Depression |  |
|  |  | Substance Abuse |  |
|  |  | Alcoholism |  |
|  |  | Hyperactivity/ADHD |  |
|  |  | Oversensitivity to Sound/Touch/Taste/Smell |  |
|  |  | Learning Problems |  |
|  |  | Autism Spectrum Disorder |  |
|  |  | Speech Problems/Delays |  |
|  |  | Eating Problems (Anorexia, Bulimia) |  |
|  |  | Post-Partum Depression |  |
|  |  | Intellectual Disability |  |
|  |  | Phobias/Fears |  |
|  |  | Down Syndrome |  |
|  |  | Anxiety |  |
|  |  | Schizophrenia |  |
|  |  | Obsessive Compulsive Disorder (OCD) |  |
|  |  | Bipolar Disorder (Manic Depression) |  |
|  |  | Other (describe:      ) |  |

Please add any relevant details you feel are important regarding items above:

Has any biological relative to your child experienced problems similar to those your child is currently experiencing?  No  Yes (explain:      )

**Recent Stressful Events and Support:**

**Please check if either parent has experienced any of the following or  None**

|  |  |  |
| --- | --- | --- |
| Major accident/illness | Moving homes | Loss of significant other |
| Financial setback | Loss of family member/friend | Difficulty as a couple |
| Separation from child | Therapy/counseling | Other (explain below) |

**Please explain all checked boxes (What happened? When? What support did you have? How did you deal with it?):**

**Please check if your child has experienced any of the following or  None**

|  |  |  |
| --- | --- | --- |
| Separation from parent | Moving homes | Addition of new sibling |
| Major accident/illness | Loss of family member/friend | Other (explain below) |

**Please explain all checked boxes (What happened? When? How did your child react?):**

**School/Education History:**

Does your child attend school/preschool/daycare? Yes  No (skip to Additional Information)

Name of child’s current school/preschool/daycare:

Address:

Telephone:       Teacher:       Grade:

Director:       Special Placement (if any):

**Please list the following information for each school/preschool/daycare your child has attended:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Name*** | ***Age at entry*** | ***Begin date*** | ***End date*** | ***Hours per day & Days per week*** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Please check all that apply to your child’s preschool / daycare / school experience or  None**

|  |  |  |
| --- | --- | --- |
| Adjustment problems | Negative reaction to school | Services through ECI |
| Services through PPCD | Services at school (speech, OT) | Extra support in classroom |
| Pull-outs (reading, math) | School completed testing | IEP or ARD |
| Repeated a grade | Asked to leave school/program | Suspended from school |
| Expelled from school | Performance below peer level | Other (explain below) |

**Please explain all checked boxes:**

**Additional Information:**

Please add any additional information or address any concerns not addressed above:

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