

CHILD HISTORY

Please use back of sheet if necessary.

CURRENT STATUS

Your name: _____ Child's full name: _____

Your relationship to child: _____ Child's date of birth: _____

Biological father's name: _____ Current age: _____

Stepmother if present: _____ Current school: _____

Stepfather if present: _____ Teacher's name: _____

Child resides primarily with: _____ Counselor's name: _____

My child's biological parents currently are married to each other, separated, divorced or widowed.

(Please circle one and explain). _____

Date of separation/divorce/death: _____

My child currently experiences the following problems: _____

My child's current overall status is: _____

My children's relationship with the other parent is: _____

My child's relationship with siblings is: _____

I believe my child would described him/herself as: _____

When not in school, my child's primary interests are: _____

My child currently participates in the following activities/lessons: _____

DEVELOPMENTAL HISTORY

Was the pregnancy planned? _____

What do you recall about your feelings about the pregnancy? _____

Did the father participate in pre-natal activities? _____

Were there any problems during the pregnancy? If so, please describe. _____

Was this child the product of a full-term pregnancy? _____

Were there any complications with the delivery? If so, please describe initially problems and any subsequent effects. _____

Was delivery vertex, breech, or caesarean? _____

Were there any post-delivery problems for the mother? If so please describe _____

Were there any post-delivery problems for this child? If so, please describe. _____

Were there any medications given to the mother or the child? If so, please explain. _____

What was the child's health status at birth? _____

Was there any further medical intervention required? _____

Were there any problems in early infancy? _____

DEVELOPMENT MILESTONES:

Sitting: _____ months
Crawling: _____ months
Standing: _____ months
Walking: _____ months
Speaking: _____ months
Toilet Training: _____ months

COORDINATION:

Walking: good____ fair____ poor____
Running: good____ fair____ poor____
Throwing: good____ fair____ poor____
Writing: good____ fair____ poor____
Catching: good____ fair____ poor____
Buttoning: good____ fair____ poor____
Tying: good____ fair____ poor____

Name of primary caregiver during infancy: _____

Name of secondary caregiver during infancy: _____

Name of primary caregiver during early childhood: _____

Name of secondary caregiver during early childhood: _____

Was child day care utilized? If so, please explain: _____

How frequently and at what age was day care used? _____

My child's current day care provider is: _____

Has your child experienced any significant developmental, health, academic, family or social problems?

If so, please explain: _____

SCHOOL

My child is in the _____ grade and is functioning at the _____ grade level

My child's school behavior is described as being: _____

My child's school conduct is described as being: _____

My child's favorite school subject(s) is/are: _____

My child's least favorite (or most difficult) school subject(s) is/are: _____

My child's relationships with peers are: _____

My child's relationships with teachers are: _____

My child's most significant problem at school seems to be: _____

My child participates in the following extracurricular activities: _____

My child's response to school and the academic process has been: _____

My child has/has not encountered any special problems? If so, explain: _____

Academic testing completed:	Yes _____	No _____	Date _____
Psychological testing completed:	Yes _____	No _____	Date _____
Eye testing completed:	Yes _____	No _____	Date _____
Hearing testing completed:	Yes _____	No _____	Date _____
Speech testing completed:	Yes _____	No _____	Date _____
Neurological testing completed:	Yes _____	No _____	Date _____

	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Child's intelligence is seen to be:	_____	_____	_____
Child's academics are seen to be:	_____	_____	_____
Child's speech is seen to be:	_____	_____	_____
Child's athletics are seen to be:	_____	_____	_____
Child's social skills are seen to be:	_____	_____	_____

ACADEMIC PERFORMANCE

Use the following numbers as they apply to describe your child's involvement, progress or performance in each area: (1) Excellent, (2) Good, (3) Average, (4) Fair, (5) Poor

PLACEMENT	GRADES	PEERS	AUTHORITY FIGURES	EX-CURRICULAR ACTIVITIES
Kinder or below				
1 st to 3 rd grades				
4 th to 6 th grades				
7 th to 8 th grades				
9 th to 12 th grades				

My child has/has not repeated a grade in school. If so, the grade/year was/were _____

My child has/has not received tutorial or special education services. If so, when/where? _____

My child has/has not been placed in or qualified for special education. If so, please complete the following:

Date of evaluation: _____

Date of placement/ARD: _____

Type of handicapping condition: _____

Type of program/service: _____

Date of discharge from program: _____

My child has/has not been placed in/qualified for honors/enriched/gifted classes. If so, please complete

Date of evaluation: _____

Date of placement: _____

Type of program/service: _____

Date of discharge from program: _____

My child has/has not received therapy? If so, explain: _____

My child's strengths are: _____

My child's weaknesses are: _____

Explain briefly any other problems: _____

MEDICAL

My child's current medical status is: _____

My child's current mental status is: _____

My child is/is not now under the care of a medical doctor/psychologist. If so, explain: _____

My child's pediatrician's name is: _____ Phone number: _____

My child's current medication is: _____

Are your child's medical records available if needed? Yes _____ No _____

Will you sign a release of information? Yes _____ No _____

List health care providers and major problems for which treatment has been sought in the past:

CIRCLE IF YOUR CHILD SHOWS ANY OF THE FOLLOWING SIGNS OR SYMPTOMS:

- | | | |
|---|-----------------------------|--------------------------|
| Truancy | Sexual abuse | Asthma |
| Rocking behavior | Tics | Eating disorders |
| Encopresis | Stomach aches/headaches | School refusal |
| Sucking on fingers or clothing | School phobia | Coordination problems |
| Restlessness | Drug/alcohol problems | Runaway from home |
| Cruelty to animals | Major illnesses | High fevers |
| Odd or unusual beliefs | Odd/unusual customs/rituals | Stealing |
| Excessive attachment to comfort objects | Fire setting behavior | Excessive day dreaming |
| Intense sibling rivalry | Outside of home placement | Physical abuse |
| Poor attention span | Speech problems | Hearing problems |
| P.E. Tubes | Brainwashing | Recurrent ear infections |
| Vision problems | Corrective lenses | Juvenile placement |
| Arrests | Peer problems | Emotional abuse |
| Hair twirling | Nail biting | Bedwetting |
| Memory problems | Allergies | Seizures |
| Suicidal ideas | Sexual acting out | Sexual preoccupation |
| Hyperactivity | ADD/ADHD | Major/frequent accidents |
| Surgeries | Authority problems | |

Please explain fully any of the problems you circled on the previous page: _____

Please include any additional information which you would like to share or which you feel would assist in gaining an understanding of your child: _____
