**Comprehensive Adopted 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:

**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.**

|  |  |  |
| --- | --- | --- |
| short attention span | attention seeking | distractibility |
| impulsivity | hyperactivity | avoidance |
| low frustration tolerance | noncompliance | skipping school |
| oppositional behavior | social isolation | anxiety |
| aggression | lying | stealing |
| setting fires | obsessive/compulsive behaviors | cruelty to animals |
| sensitivity to environment | temper tantrums | cries easily |
| overly shy | difficulty with transition | clingy to parent |
| irritable/inconsolable | attachment difficulties | hoarding behaviors |

Please explain all checked boxes:

Do you have concerns regarding your child’s ability to form an attachment with you?

No  Yes, explain:

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:

**Adoption Information:**

Date of adoption:       Age of child at adoption:

International adoption?  Yes  No

Place of adoption:

Was your child in a:  Foster Home  Orphanage  None  Other (explain:      )

At what age did this child enter into your care?

Were the adoptive parents married/together at the time this child was adopted:  Yes  No

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

Are the adoptive parents currently together?  Yes  No

What adoption agency did you use?

How did you prepare for the adoption?  Internet  Classes  Books  Other:

Please list any websites, books or classes you found particularly helpful:

Was it what you expected?  Yes  No

explain:      ­­­­­

Did you feel you were aware of the potential risks?  Yes  No

explain:

Did either parent experience the “adoption blues”?  Yes  No

explain:

Did either parent experience Post-Adoption Depression Syndrome (PADS)?  No  Yes

explain:

Have you ever considered disruption?  No  Yes

explain:

Does your child know he/she is adopted?  No  yes

If yes, what was your child told?

Please add any additional information regarding the adoption of this child:

**Pre-Natal History:**

**Check here if no information is available regarding pre-natal history.**

**Please answer the following questions to the best of your ability regarding pre-natal history.**

Did the birth mother have any other full-term pregnancies?  Yes  No  Unknown

Did the birth mother have any miscarriages, stillbirths or abortions?  Yes  No  Unknown

Was the birth mother married during this pregnancy?  Yes  No  Unknown

Did the birth mother receive pre-natal care during this pregnancy?  Yes  No  Unknown

Does this child have any biological siblings?  Yes  No  Unknown

If yes, is he/she aware of them?  No  Yes (what was he/she told?      )

Is the birth mother listed on the register (Russia)?  Yes  No  Unknown

Please add any other information regarding pre-natal history:

**Check Yes / No for the items below that you are aware 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:**

**Check here if no information is available regarding 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 biological mother at birth:       Age of biological father at birth:

**Check all that you are aware may 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:**

**Check here if no information is available regarding post-delivery history.**

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

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

**Check Yes / No for the items below that you are aware 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:**

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

Did your child speak in his/her native language prior to adoption?  Yes  No

If yes, did he/she use:  single words  word combinations

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 any 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 above 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:      ) |

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

**Biological Family Health History:**

**Check here if no information is available regarding biological 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:

**Biological Family Emotional and Learning History:**

**Check here if no information is available regarding biological family emotional / 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

**Adoptive Family Health History:**

Please provide any information you feel is important regarding this child’s adoptive family’s health and emotional history:

**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:      ) |

**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:      ) |

**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:      ) |

**Please explain all checked boxes:**

**Additional Information:**

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

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