Child History Form

Please take some time before your initial visit to complete this form as thoroughly as possible. This will allow for a more comprehension initial assessment appointment. If possible, please return the form prior to your initial assessment, or bring it to your appointment. Please bring any treatment records, diagnostic report and/or school records to the initial assessment.

Client Name	Date of Birth
Printed Name of Parent/Guardian completing this form	
Relationship to the Client	

Family Information

	Name	Age	Living in same home as child?
Mother			☐ Yes ☐ No
Father			☐ Yes ☐ No
Siblings			☐ Yes ☐ No
Other relatives/caregivers			☐ Yes ☐ No

Custody and placement arrangements, if any; please indicate if either parent's legal rights have been terminated.

Is the child adopted? ☐ Yes ☐ No

Have there been any significant changes in family life or family structure? (Birth, death, divorce, foster placement, recent move etc)? ☐ Yes ☐ No

If yes, please explain:

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Prenatal, Birth and Infancy

	Check One	Comments
High blood pressure	☐ Yes ☐ No	
Gestational diabetes	☐ Yes ☐ No	
Seizures during pregnancy	☐ Yes ☐ No	
Illness during pregnancy	☐ Yes ☐ No	
Hurt or injured during pregnancy?	☐ Yes ☐ No	
Alcohol, tobacco or drug use during pregnancy?	☐ Yes ☐ No	
Medications taken during pregnancy?	☐ Yes ☐ No	
Was your child born near due date?	☐ Yes ☐ No	
Birth weight		
Early infant feeding challenges	☐ Yes ☐ No	
Irregular sleep patterns	☐ Yes ☐ No	
Colic	☐ Yes ☐ No	

Was there anything unusual about the delivery (induced labor, C-section, excessive bleeding, breech presentation, cord around neck, etc.)? ☐ Yes ☐ No
If yes, please describe:

Was there anything unusual after the delivery (breathing problems, jaundice, low Apgar scores, incubator care, etc.)? ☐ Yes ☐ No
If yes, please describe:

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Developmental Milestones

	Check one			Comments
Rolled over	☐ Early	☐ Typical Range	☐ Late	
Slept through night	☐ Early	☐ Typical Range	☐ Late	
Sat without support	☐ Early	☐ Typical Range	☐ Late	
Crawled	☐ Early	☐ Typical Range	☐ Late	
Walked independently	☐ Early	☐ Typical Range	☐ Late	
Spoke first words	☐ Early	☐ Typical Range	☐ Late	

Does your child have any sensory sensitivities (tactile, visual, auditory, etc)? ☐ Yes ☐ No
If yes, please describe:

Medical History

	Check One	If yes, Date	Comments
Allergies	☐ Yes ☐ No		
Ear infections	☐ Yes ☐ No		
Chronic conditions (asthma, heart condition, diabetes, etc.)	☐ Yes ☐ No		
Seizures	☐ Yes ☐ No		
Surgery	☐ Yes ☐ No		
Injury (head injury, broken bone(s), burns etc.)	☐ Yes ☐ No		
Vision problem	☐ Yes ☐ No		
Hearing problems	☐ Yes ☐ No		
Any serious illness or injury?	☐ Yes ☐ No		
Feeding problems?	☐ Yes ☐ No		
Motor delays or differences?	☐ Yes ☐ No		

Current Medications **(name, dosage and name of prescriber)**

Past Medications **(name, dosage, name of prescriber, and response to medication)**

Intervention and School History

Has your child ever been evaluated for developmental concerns? ☐ Yes ☐ No

If yes, please describe concerns, doctor or clinician who evaluated your child and results / diagnosis:

Has your child received any of the following services?

	Choose one	If yes, date / provider of services & type of therapy
Birth to Three	☐ Yes ☐ No	
IEP through School	☐ Yes ☐ No	
Private occupational therapy, speech therapy or physical therapy	☐ Yes ☐ No	
Psychotherapy (individual / family / group	☐ Yes ☐ No	
Other	☐ Yes ☐ No	

Additional comments regarding past / current therapies:

Please describe your child's school history. Include name of school, city, and age or grade of attendance. Please also indicate if any behavior, academic concerns, social or other concerns raised by any teachers or caregivers as well as any comments about your child's adjustment to school.

Daycare

Preschool / Early Childhood

Elementary School

Middle School

High School

Has your child ever been placed outside of the home (foster care, residential center, etc?) ☐ Yes ☐ No
If yes, please describe:

History of trauma (serious/life threatening injury, assaults, abuse) or threatens / attempts suicide not already mentioned? ☐ Yes ☐ No
If yes, please describe:

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Family History

Biological relatives (brothers, sisters, mother, father, aunts, uncles, and grandparents) suffered from any of the following conditions?

Please specify family member and whether it is paternal (father's relative) or maternal (mother's relative)

	Chose one	If yes, please indicate who (mother, father, cousin, grandfather, etc.)
Anger / Aggression	☐ Yes ☐ No	
Anxiety / Panic Attacks	☐ Yes ☐ No	
Hyperactivity or ADHD	☐ Yes ☐ No	
Autism Spectrum Disorder	☐ Yes ☐ No	
Learning or Education Problems	☐ Yes ☐ No	
Bipolar Disorder	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Learning Disability	☐ Yes ☐ No	
Oppositional Behavior	☐ Yes ☐ No	
Tics or Tourette Syndrome	☐ Yes ☐ No	
Alcohol or substance abuse	☐ Yes ☐ No	
Criminal offenses	☐ Yes ☐ No	
Suicide Attempt / Suicide	☐ Yes ☐ No	
Schizophrenia / Schizoaffective Disorder	☐ Yes ☐ No	
Physical or Sexual Abuse	☐ Yes ☐ No	
Seizures of other Neurological condition	☐ Yes ☐ No	

Current Concerns

Please describe your current concerns and what led you to seek consultation:

Please describe the child's strengths and abilities:

Family Goals & Priorities

Please describe your goals and priorities for your child:

Parent/Guardian Signature: