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Child Information Form

Date Completed: _____

IDENTIFYING INFORMATION

Child's Name _____

Birthdate _____ Age _____

Sex Male Female

Home Address _____

Phone _____

Ethnicity/Race _____

Person completing form _____ Relation to child _____

Referred by _____

Family Physicians (include address and phone number)

1. _____

2. _____

REASONS FOR EVALUATION:

Please state your concerns; specify nature of problem, duration, frequency, severity:

Did a specific event lead to this evaluation?

Yes No. If so, please describe:

BIRTH HISTORY:

This information should be provided as it relates to the biological parents of your child, if known:

- 1. Was the pregnancy planned? Yes No
- 2. Was the mother exposed to any of the following:

<u>TYPE</u>	<u>LIST SPECIFIC SUBSTANCES</u>	<u>AMOUNT</u>	<u>MONTH of PREG</u>
<input type="checkbox"/> DRUGS	_____	_____	_____
<input type="checkbox"/> ALCOHOL	_____	_____	_____
<input type="checkbox"/> TOBACCO	_____	_____	_____
<input type="checkbox"/> MEDS	_____	_____	_____
<input type="checkbox"/> X-RAYS	_____	_____	_____

- 3. Did the mother experience any of the following during pregnancy?

	<u>DESCRIBE THE PROBLEM</u>	<u>MO OF PREGNANCY</u>
<input type="checkbox"/> FEVER	_____	_____
<input type="checkbox"/> FLU	_____	_____
<input type="checkbox"/> OTHER ILLNESSES	_____	_____

- 4. Did the mother experience any of the following during pregnancy? If yes, please describe.

- Swelling hands, feet or face _____
- High blood pressure _____
- Dizzy spells _____
- Convulsions _____
- Headaches _____

6. Length of pregnancy: _____ Age of mother: _____ Weight Gain: _____

- 7. Was the labor with your child Easy, No Problems Difficult; please explain:

8. Were there any problems with the delivery? Yes No If yes., please explain:

9. Was the birth: Natural C-section

10. Measurement of your child at birth:

Birth weight: _____ Length: _____

11. Duration of mother's hospital stay? _____ Baby's hospital stay? _____

12. Were there any problems noted by anyone while the baby was still in the hospital? (For example, prolonged jaundice, need for incubator/oxygen, infections, feeding problems, convulsions?)

13. Please list all pregnancies of natural mother including miscarriages, in chronological order.

	Year	Length of Pregnancy	Difficulties during pregnancy	Living/ normal child	If not, explain
1					
2					
3					
4					
5					
6					

EARLY INFANCY

1. Were there any difficulties during the baby's first month of life? (Excessive crying, medical problems, etc.)? Yes No If yes, please describe.

2. Were there any difficulties with feeding such as recurrent vomiting, "colic", poor sucking, inadequate weight gain? Yes No If yes, please describe.

3. Did parents have trouble adjusting to the new baby? Yes No If yes, describe.

DEVELOPMENTAL HISTORY

1. When did your child first (approximate age):

Motor	Age	Language	Age	Social	Age
Sit alone	_____	Laugh	_____	Smile	_____
Walk alone	_____	Babble	_____	Recognize strangers	_____
Ride a tricycle	_____	Say mama/dada	_____	Drink from a cup	_____
Ride a bicycle	_____	Use first words	_____	Put clothes on	_____
		Put 2 words together	_____		
		Use full sentences	_____		
		Recognize colors	_____		

Toilet Training

	Age
Bowel	_____
Bladder	_____

2. Were parents worried about child’s development? Yes No If yes, please describe: _____

3. Was development perceived as being Normal Slow Accelerated

CURRENT CHILDHOOD SKILLS

1. Can your child perform the following independently?

- Eating using a spoon and fork?
- Cut meat with a knife?
- Drink from a glass?
- Undress?
- Dress alone?
- Tie shoelaces?
- Toilet him/herself?
- Bathe him/herself?

2. Does your child currently have any problems with:

- Gross motor skills? _____
(use of large muscles, such as for running, bicycling)
- Fine motor skills? _____
(hand use such as for coloring, cutting, drawing, handwriting)
- Language skills? _____
- Social skills? _____
- Self control skills? _____
(impulse control, ability to pay attention)
- Self concept _____
(child’s opinion of self and abilities)

3. What games and activities does your child prefer? _____

4. Are chore routines assigned to your child? Yes No If yes, which ones?

FAMILY HISTORY

Mother's Name: _____ Birthdate: _____
 Occupation: _____ Educational level attained: _____
 History of learning problems? Yes No If yes, what kind?

Marital Status _____

Father's Name: _____ Birthdate: _____
 Occupation: _____ Educational level attained: _____
 History of learning problems? Yes No If yes, what kind?

Marital status _____

FAMILY MEDICAL HISTORY

Does anyone in your family have any of the following conditions? Check all that apply, past or present:

Symptom	Mother	Father	M's Family	F's Family	Sibling
<input type="checkbox"/> Mental Retardation	_____	_____	_____	_____	_____
<input type="checkbox"/> Learning Disorder	_____	_____	_____	_____	_____
<input type="checkbox"/> Attention Deficit	_____	_____	_____	_____	_____
<input type="checkbox"/> Hyperactivity	_____	_____	_____	_____	_____
<input type="checkbox"/> Epilepsy	_____	_____	_____	_____	_____
<input type="checkbox"/> Neurological diseases	_____	_____	_____	_____	_____
<input type="checkbox"/> Alcoholism	_____	_____	_____	_____	_____
<input type="checkbox"/> Drug abuse	_____	_____	_____	_____	_____
<input type="checkbox"/> Child abuse	_____	_____	_____	_____	_____
<input type="checkbox"/> Sexual abuse	_____	_____	_____	_____	_____
<input type="checkbox"/> Depression	_____	_____	_____	_____	_____
<input type="checkbox"/> Suicide	_____	_____	_____	_____	_____
<input type="checkbox"/> Mental Illness	_____	_____	_____	_____	_____
<input type="checkbox"/> Vision problems	_____	_____	_____	_____	_____
<input type="checkbox"/> Hearing problems	_____	_____	_____	_____	_____
<input type="checkbox"/> Tourette Syndrome	_____	_____	_____	_____	_____
<input type="checkbox"/> Chronic Illnesses	_____	_____	_____	_____	_____

Symptom	Mother	Father	M's Family	F's Family	Sibling
<input type="checkbox"/> Delinquency	_____	_____	_____	_____	_____
<input type="checkbox"/> Miscarriages	_____	_____	_____	_____	_____
<input type="checkbox"/> Birth Defects	_____	_____	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____	_____	_____

If you are not the biological parent of the child, please complete the following if known:

Biological mother's occupation: _____ Educational level attained _____

History of learning problems? Yes No General Health _____

Biological father's occupation: _____ Educational level attained _____

History of learning problems? Yes No General Health _____

SOCIAL HISTORY

1. With whom is your child currently living (list other members of household):

Household Member	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. How many times have you moved in the last 5 years? (Specify where you have lived).

3. Are there currently any unusual stresses your family is experiencing?

PAST MEDICAL HISTORY OF CHILD

1. Is the general health of your child good? Yes No If no, please describe:

2. Please describe any:

Serious illness now (or in past): _____

Chronic illnesses now (or in past): _____ \

Allergies: _____

Sleep problems (too much/too little): _____

Are immunizations up to date: _____

Has child had any seizures: _____

If yes, specify type, duration, frequency and date of last EEG: _____

3. Hospitalizations (since birth):

Hospital	Dates
Reason	

4. Has your child had any operations? Yes No Please specify when and where:

5. Has your child had any serious injuries or accidents? Yes No

6. Any head injuries? Any episodes of loss of consciousness? Yes No

7. Is your child on any medications at this time? (Specify amount and frequency) Yes No

8. When was your child last seen by a physician? For what reason?

9. Has your child had any of the following (please give details):

- recurrent headaches _____
- recurrent stomach aches _____
- recurrent diarrhea _____
- recurrent vomiting _____
- constipation _____
- vision problems _____
- hearing problems _____
- ear infections _____
- recurrent respiratory infections (bronchitis/bronchiolitis or pneumonia) _____
- wheezing or asthma _____
- bladder problems _____
- weight loss or gain _____
- skin problems _____
- problems with bones, muscles, or joints _____
- tremor, shakes or jitters _____
- tics or other movement problems _____
- wets bed or him/herself _____
- soils bed or him/herself _____

other _____

10. Have you noticed any change in the last six months in :

eating (either increase or decrease) _____

sleeping (either increase or decrease) _____

mood (increase or decrease in happy or sad feelings) _____

types of friends _____

BEHAVIORAL HISTORY

1. How is your child's overall emotional health?

2. Does your child have behavioral problems at home? (Please specify) _____

3. Does your child have behavior problems at school? (Please specify) _____

4. Please describe forms of discipline which have been used in the home and their effectiveness

5. Please make a brief statement about the relationship between your child and Mother (or primary caretakers):

a. Father: _____

b. Siblings: _____

6. How has your child's problem affected each family member: Mother _____

Father: _____ Siblings _____

7. Please list those qualities about your child that you consider to be strong positive points:

8. Please list those qualities about your child that you consider to be strong negative points:

SCHOOL HISTORY

Current School: _____ District _____ Grade: _____

Teacher _____ Principal _____ Phone Number: _____

Does your school know about this evaluation? _____

Is your child in any special classes or programs, or receiving any special services (tutoring, resource room physical/occupational therapy, speech therapy)? _____

If not now, has your child received any of these services in the past?

Please list all schools attended:

Type	Address	Grade	Dates

Identify the following:

Favorite subjects? _____

Best subjects? _____

Worst subjects? _____

Is your child having trouble in particular areas? Which ones? _____

Has your child been previously tested at school? _____ If so, when? _____

Are you seeking help from any other agency or clinic at this time? _____ If yes, please specify _____

Please list all other persons or agencies who have evaluated your child in the past:

Type of Service	Service provider/address	Results of trxt	Dates

What do you hope to get from this evaluation?
