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HISTORY FORM

Thank you for taking the time to complete this form. This information is essential to my being able to conduct a thorough evaluation.

CLIENT'S NAME:_____ Birthdate: _____

Preferred pronouns:_____

Completed by:_____ Date completed:_____

Parent /Guardian _____Phone: (h) _____

Address: _____ (w) _____

City: _____Zip: _____

School: _____ District: _____

Teachers:_____ Grade: _____

Phone: _____

Please list any current therapies your child is receiving with provider name and phone number:

Therapy	**Provider**	**Phone**	**Date Begun**

Birth and Developmental History:

Information requested pertains to the biological mother of the child:

1. Did the mother receive prenatal care? Y N

2. Did the mother take any medications during pregnancy? Y N

Name of medication	Reason taken	Trimester

3. Did the mother smoke cigarettes, drink alcohol, or use drugs during pregnancy? Y N

Substance	Amount used per week	Trimester

4. Did the mother experience any medical problems during pregnancy? Y N If so, please describe:

5. Length of pregnancy: _____ weeks Age of mother:_____

6. Were there any problems with the delivery? Y N If so, please describe:

Delivery was: Vaginal___ C-section___

7. Birth weight:_____
8. Duration of mother's hospital stay: _____ Baby's hospital stay:_____
9. Were there any problems noted by anyone while the baby was still in the hospital? (for example, prolonged jaundice, need for incubator/oxygen, feeding problems, colic) _____

10. Did your child have any medical problems during infancy? _____

Feeding difficulties?_____

"Colic"?_____

Sleep difficulties?_____

11. How would you describe your child's temperament as an infant? (Was he/she/they an "easy" baby? Was he/she/they cuddly?) _____

_____

12. At what age did your child complete the following developmental milestones?

Milestone	Age
Smile	_____
Sit	_____
Walk	_____
First words (other then "mama" and "dada")	_____
2-3 word sentences	_____
Toilet trained during day	_____

Medical History

1. Does your child have any chronic health issues (e.g. asthma, genetic syndromes, diabetes)?

_____

_____

2. Has your child had any surgeries or hospitalizations? Y N

Year of surgery	Procedure/Reason for Hospitalization	Outcome

3. Has your child ever had a seizure? Y N

If so, please describe dates of seizures, any diagnostic testing performed, and any medications given.

_____

_____

4. Has your child ever had a head injury? Y N

If so, please describe dates and circumstances. Did your child lose consciousness? Was a CT scan or MRI performed? _____

_____

5. Is your child taking any type of medication currently? Y N

Name of medication Dosage Reason Date begun

6. Has your child ever taken any psychiatric medications in the past? Y N

Name of medication Dosage Reason Dates

7. Has your child ever had a vision screen? Y N

Date of screen:_____ Results:_____

8. Has your child ever had a hearing screen? Y N

Date of screen:_____ Results:_____

9. Please list any evaluations for your child (neurology, developmental pediatrics, psychologist). **Please bring copies of these evaluations to your first appointment.**

Type By whom Year Diagnoses

_____

_____

_____

General Information

1. Please list information regarding child's legal parent(s):

Name _____ _____

Educational level _____ _____

Occupation _____ _____

Age _____ _____

Religion/Spirituality _____ _____

2. Are parents currently living together? Y N

If not, describe custody arrangement:_____

_____

3. Please list sibling(s):

Name	Age	Full/half/adoptive/step?	Living in your home?

4. If your child is on a special diet, please describe: _____

_____

5. If your child has any sensitivities to light, noise, touch, etc. please describe: _____

_____

6. Does your child currently have any problems with sleep? (e.g., falling asleep, frequent wakings)

_____

7. Please list the goals you have for our work together: _____

_____

_____

_____

Family History

Do any of your child's biological relatives have the following conditions? Please check all that apply, past or present.

	MOTHER	FATHER	MOTHER'S FAMILY	FATHER'S FAMILY	CHILD'S SIBLINGS
Attention Problems					
Social Awkwardness					
Learning problems					
Language Delay					
Autism Spectrum					
Hyperactivity					
Problems w/ Anger					
Drug/Alcohol Abuse					
Depression					
Suicide Attempt(s)					
Problems w/ Anxiety					
Bipolar Disorder					
Schizophrenia					
Psychosis					
Criminal History					