PEDIATRIC HISTORY FORM

Child's Name: _____ Date of Birth: _____

Age: _____ Gender: _____ Grade: _____ Corrected Vision: **Glasses** **Contact Lens** **None**

Form completed by: _____ Relationship to child:_____

Which parent(s) have legal custody of child? _____

Note: If divorced or separated, please provide documentation at the time of appointment showing that the identified parent/guardian has the right to make decisions for the child. If not, please provide documentation that other parent has provided permission for this evaluation.

Phone: _____Email: _____

Who referred your child for this evaluation? _____

Are you concerned about?: ☐ ADHD ☐ Autism/ Asperger's ☐ Learning Disability ☐ Intellectual Disability

☐ Anxiety ☐ Depression ☐ Other: _____

Please describe current concerns and why you want your child evaluated:

When were these concerns first noticed?

DEVELOPMENTAL/ MEDICAL HISTORY

Length of pregnancy? (full term is 40): _____weeks Birth Weight: _____

Any pregnancy or birth complications?

During the pregnancy, any history of smoking? _____ alcohol use? _____ other substances? _____

If yes, please explain:

Check any of the following developmental problems your child has now or has had in the past:

□ Hearing □ Gross motor (walking, running) □ Feeding/eating

□ Speech/language □ Fine motor (writing) □ Social skills

□ Vision □ Sleeping □ Other: _____

Milestone	Normal Limits	Within Normal Limits	If "No" please indicate at what age it did occur
Crawling	7-10 months	☐ Yes ☐ No	
Walking	10-15 months	☐ Yes ☐ No	
First words	12-19 months	☐ Yes ☐ No	
2-4 word phrases	2 years	☐ Yes ☐ No	
4-5 word sentences	3 years	☐ Yes ☐ No	

Please describe your child's medical conditions:

Please list any recent hospitalizations and reason they were hospitalized:

Describe any past surgeries:

Describe any head injuries/ concussions/ seizures and if they lost consciousness:

List any medications your child is **CURRENTLY** taking and what they are for:

Has your child previously taken any stimulant medication (e.g., for attention problems/ ADHD)? **YES NO**

Has your child previously taken medication for mood, depression, anxiety? **YES NO**

Any concerns about/changes to your child's sleep?

Typical bed time: _____ Typical wake time: _____

Trouble falling asleep: **YES NO** Trouble staying asleep: **YES NO** Trouble waking up: **YES NO**

Any concerns about or changes to your child's eating/appetite?

Was your child toilet trained by age 5? **YES NO** Any daytime or nighttime toileting accidents? **YES NO**

Vision problems: Hearing problems:

Any history of ear infections/ ear tubes? Please describe:

Any problems with talking or understanding language?

Any allergies:

Does your child have any trouble with daily living tasks they should be able to do at their age (i.e., dressing themselves, bathing, toileting, helping around the house, etc.):

Any sensory concerns (e.g., loud noises, smells, textures, tags on clothes, etc.)? Please describe:

Any unusual movements or behaviors? Please describe:

EDUCATIONAL HISTORY

Current School: _____Grade: _____

Has your child ever been evaluated for special education services? **YES NO**

Please describe (e.g., when/ what was the outcome):

Does your child **currently** have an IEP? _____ 504 Plan? _____ When started? _____

Check if your child has received/ is receiving any of the following services:

Service	Describe (e.g., since when/ frequency)	Location
☐ Academic Support/ Tutoring		☐ At school ☐ Other:
☐ Speech/Language Therapy		☐ At school ☐ Other:
☐ Occupational Therapy (OT)		☐ At school ☐ Other:
☐ Physical Therapy (PT)		☐ At school ☐ Other:
☐ Counseling		☐ At school ☐ Other:
☐ Other:		☐ At school ☐ Other:

Has your child ever been diagnosed with a learning disability? **YES NO**

Has your child ever repeated or skipped a grade? _____

Please list all schools attended and the grades child was there (K, 1st, 2nd, etc.):

Describe child's grades/ academic performance (past and present):

Please describe any behavioral/discipline, social, or emotional problems your child has had at school:

PSYCHOLOGICAL/ SOCIAL HISTORY:

Has the child been evaluated previously by a psychologist/ psychiatrist/therapist? Please describe:

Is your child currently being seen by a psychiatrist for medication? **YES NO** If yes, please describe.

Is your child currently attending counseling/therapy? If yes, please describe who and how often.

Does your child have a history of self-harm or suicidal thoughts, threats, or attempts? Please describe:

Has your child ever been hospitalized for mental health concerns? Please describe:

Any difficulty with eye contact in the past or currently? **YES NO**

Any difficulty making friends or maintaining relationships either now or in the past? Please describe:

Any history of being bullied or bullying others? Please describe:

Any history of trauma or abuse? Please describe:

Any history or suspicion of drug, alcohol, or cigarette use? Please describe:

Has child had any involvement with law enforcement (arrests, probation, etc.)?

Any recent, significant deaths of family members or close relatives?

Any significant separations from family members?

Has the child ever been removed from the home or parent custody?

Any significant stress in the home currently?

What language is usually spoken in the home? _____

What language does child usually speak? _____ Any other languages? _____

1. Legal Guardian(s):

- ☐ Biological Parents
- ☐ Biological Mother
- ☐ Biological Father
- ☐ Other (specify) _____
- ☐ Adoptive Parents
- ☐ Adoptive Mother
- ☐ Adoptive Father
- ☐ Step-Mother
- ☐ Step-Father
- ☐ Foster Parent
- ☐ Group Home
- ☐ Tribal Services
- ☐ Court

2. Marital Status of Parents (check one):

- ☐ Single
- ☐ Married
- ☐ Married, living apart
- ☐ Married, separated
- ☐ Divorced (check custodial status)
  - ☐ Joint custody
  - ☐ Sole custody (check which parent)
    - ☐ Mother
    - ☐ Father

Name of child's mother: _____ Lives with child? ____ Yes ____ No

Highest level of education: _____ Current Occupation: _____

Name of child's father: _____ Lives with child? ____ Yes ____ No

Highest level of education: _____ Current Occupation: _____

Other Guardian(s): _____ Lives with Child? ____ Yes ____ No

Highest level of education: _____ Current Occupation: _____

Please list first names, ages, and relationships of all others in the child's home:

Does your child currently have a job? If yes, where and for how long? _____

Any past employment? _____

Check any of the following if they are present in your child's family's history:

	Mother	**Father**	**Mother's Parents**	**Father's Parents**	**Sibling(s)**	**Other: (_____)**
Anxiety						
Depression						
ADHD						
Autism/Asperger's						
Bipolar Disorder						
Schizophrenia						
Intellectual Disability						
Suicide/ Self Harm						
Alcohol abuse						
Substance abuse						
Learning Difficulties/ Special Education Services						

Anything else that you were not asked about that you think would be important to know: