



Initial History Form – Children and Adolescents

General Information

Child's Name: _____ Today's Date: _____

Child's Date of Birth: _____ Child's Age: _____ Sex: Male Female

Person completing form: _____ Relationship to child: _____

Address: _____

Home phone: _____ Work phone: _____ Cell phone/other: _____

Child's primary physician, address, and phone: _____

Child's neurologist and/or neurosurgeon: _____

Referral Information

Who referred you for an evaluation/psychological services? _____

What are you hoping to gain from these services? _____

What do you think is the major cause of this child's difficulties? _____

Describe some of this child's strengths: _____

Describe some of this child's weaknesses: _____

Do caregivers agree about the nature and causes of the problem? _____

Pregnancy and Birth History

Child is: biological adopted (at age _____) foster (at age _____)

Were you (or the biological mother if adopted/foster) under a doctor's care? No Yes

Number of previous: pregnancies _____ miscarriages _____

Circle any of the following health complications that occurred during the pregnancy and provide detail if able.

Fertility problems	Vaginal bleeding	Toxemia	High blood pressure
Gestational diabetes	Trauma	Fever/rash (e.g., flu, measles)	Emotional problems
Abnormal weight gain	Anemia	Excessive swelling	Excessive vomiting
Blood incompatibility	Smoking	Alcohol	Illicit drugs
Medications	Hospitalization(s)	X-rays _____	Other: _____

Medications, tobacco, alcohol, or other drugs during pregnancy: _____

Age of mother at delivery: _____ Age of father at delivery: _____ Age of mother at birth of first child: _____

Birth weight: _____ lbs. _____ oz. Length of pregnancy: _____ weeks Length of labor: _____ hours

Apgar scores: _____ Delivery was: vaginal Cesarean (reason: _____)

Circle any of these complications that occurred during delivery/birth and provide detail if able.

Breech position	Cord around neck	Meconium staining	Lacking oxygen/hypoxic	Forceps used
Labor induced	Abnormal color _____	Phototherapy _____	Other: _____	

Did baby breathe spontaneously? No Yes

Oxygen required? No Yes If yes, for how long? _____

Transfusion required? No Yes If yes, why and how many? _____

Length of stay in hospital: Mother: _____ days Child: _____ days

Medical problems after discharge (e.g., fever, apnea, surgery) _____

Any problems in first few months? No Yes Explain: _____

Did mother experience postpartum (after birth) depression? No Yes _____

Describe this child's temperament as an infant: _____

Developmental History

Motor

Age sat alone: _____ crawled: _____ stood alone: _____ walked alone: _____

Slow to develop motor skills or awkward compared to siblings/friends? _____

Handedness: right left Ambidextrous/both Age established hand dominance _____

History of physical therapy? When & why _____

History of occupational therapy? When & why _____

Speech/Language

Age spoke first word: _____ expressed 2-3 word phrases: _____ spoke in structured sentences: _____

Oral motor problems (e.g., late drooling, poor sucking, poor chewing)? _____

Speech delay/problems (e.g., stutters, difficult to understand)? _____

History of speech/language therapy? When & why _____

Other language spoken in home (besides English)? _____

Toileting

Age trained for bladder _____ Age trained for bowels _____ Bed wetting? _____ If yes, until age= _____

Urine accidents during the day? Until age= _____ When/where did this occur? _____

Soiling accidents? Until age= _____ When/where did this occur? _____

Current wetting or soiling problems? Explain: _____

Medical History

Circle any of the following that apply. Indicate age and duration if able.

Failure to thrive	Febrile seizures	Diagnosed Epilepsy	Staring spells	Lead poisoning
Toxic ingestion	Meningitis	Encephalitis	Asthma	Allergies
Diabetes	Loss of consciousness	Stomach pain	Vomiting	Headaches
Constipation	Urination problems	Accident prone	Frequent ear infections	Sleep problems
Eating problems	Tics/twitching	Repetitive movements	Impulsivity	Temper tantrums
Nail biting	Clumsiness	Head banging	Self-injurious behavior	Rocking back and forth

Has vision been checked? No Yes Any problems? _____

Has hearing been checked? No Yes Any problems? _____

History of ear tubes? No Yes If yes, when and how many sets? _____

List any serious illness, injury, surgery (etc.) AND age of occurrence. Specifically describe any head injuries (loss of consciousness, associated symptoms, etc.) _____

If any of the following have been performed, list dates and results.

CT of brain/head _____
brain/stem MRI _____
EEG _____
MRA of head _____
SPECT or PET _____
MEG _____
Any other non-routine exams involving the brain/nervous system _____
Current medications and reasons: _____

Family Medical History

Describe any family history of problems with:

Learning or attention _____
Psychiatric (e.g., depression, anxiety, schizophrenia, bipolar) _____
Alcoholism or substance abuse _____
Autism _____
Mental retardation _____
Neurological (e.g., Alzheimer's, Parkinson's, epilepsy) _____
Other (e.g., hypertension, cancer, diabetes, migraines, heart disease) _____
Anyone else in family have problems similar to this child's reason for referral? _____

Family Information

Mother's name: _____ Age: _____ Education: _____
Occupation: _____ Employer: _____
Father's name: _____ Age: _____ Education: _____
Occupation: _____ Employer: _____
Parents are: married separated divorced never married Other _____
Describe current relationship between parents (e.g., loving, friendly, civil, volatile) _____
Do parents generally agree on discipline/child rearing strategies? No Yes If no, explain _____
If divorced, list custody and visitation arrangements _____

List all brothers and sisters, and any other members of the household(s).

Age	Sex	Name/relationship to this child	Living at home?	Problems?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Is this child in a child-care setting? No Yes If yes, how many hours/day? _____
Has this child experienced death of loved one or separation from loved one? No Yes If yes, explain: _____

Social History and Adaptive Functioning

Does this child:

- have difficulty relating to or playing with other children? No Yes
- interact better with adults than children his/her own age? No Yes
- have difficulty making/keeping friends? No Yes
- understand social gestures? No Yes
- have a good sense of humor? No Yes
- understand social cues well (e.g., knows when others are angry)? No Yes
- have problems with peer pressure (e.g., alcohol or drug use)? No Yes
- show a desire to please you? No Yes
- manage change in routine/expectation well? No Yes
- require excessive prompting to complete chores/responsibilities? No Yes

When did you first become concerned about his/her social, emotional, behavioral functioning? _____

Psychological History

List any previous direct contact with any social agency, psychologist, or psychiatrist.

Name and type of professional	Reason for services	Date(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe this child's typical mood: _____

Academic History

Current school and address: _____

Grade: _____ Placement: regular resource special education other _____

Has this child been tested for special education? No Yes Results: _____

Does this child have an IEP? No Yes If yes, describe: _____

Any grades that were skipped or repeated? No Yes Explain: _____

Circle any of the following for which teachers have reported problems.

- Reading
- Spelling
- Math
- Writing
- Attention/concentration
- Behavior/emotion
- Social adjustment

Describe any academic problems that occurred in:

Preschool _____

Kindergarten _____

Early elementary school (1st to 2nd) _____

Upper elementary school (3rd to 5th) _____

Middle school (6th to 8th) _____

High school _____

Additional Comments: _____
