Child's History Questionnaire

Child's Full Name:_____
Child's Date of Birth_____

Name of the person completing this form: _____

Today's date:
_____

Contact Information:

Parent's full name: _____
Address: _____
_____
Phone #'s _____
Age: _____
Profession and/or
work activity _____

Parent's full name: _____
Address: _____
_____
Phone #'s _____
Age: _____
Profession and/or
work activity _____

Other primary caregiver (Guardian/Significant Other/Other)
Caregiver's full
name _____
Phone #'s _____
Age: _____
Profession and/or
work activity _____

Emergency Contact (other than primary caregiver):
Name : _____
Address: _____
_____
Phone #'s _____

What are the main concerns that you have about your child?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Child's Race and Religion:

Race/Ethnicity:		Religion	
American Indian/ Alaska Native	_____	Protestant	_____
Asian: Indian/Pakistani	_____	Muslim	_____
Asian: Chinese	_____	Jewish	_____
Asian: Other-specify	_____	Hindu	_____
Hispanic or Latino	_____	Catholic	_____
Black/African American	_____	Buddhist	_____
White/Caucasian	_____	Other: Specify	_____
Other: Specify	_____	None	_____

Is the child adopted? Yes_____ No _____

Other children in the family.

Name	Gender	Date of Birth	Age	Relation to child

Other persons living in the home (significant other, friend, grandparents, foster child, etc)

Name	Gender	Date of Birth	Age	Relation to child

Languages spoken in the home_____

Agencies or professionals currently providing services to your child and family.

Agencies or professional	Age of child when services begun

Pregnancy History

During pregnancy with this child did the mother experience any of the following?

Medical Problems No ____ Yes ____ If yes, how long _____

Special diet No ____ Yes ____ If yes, how long _____

Medications No ____ Yes ____ If yes, how long _____

Length of pregnancy Full-term (38-42 weeks) No ____ Yes ____

Number of weeks at birth _____

Any accidents/injuries No ____ Yes ____ If yes, describe_ _____

Birth History

Age of mother at birth of child _____

Complications for mother during delivery No _____ Yes _____

If yes, list _____

_____

_____

Child's birth weight _____

Did the child need:

Oxygen No _____ Yes _____ if yes, why? _____

Special care No _____ Yes _____ if yes, why? _____

How long did the child stay in the hospital after birth? _____

How long did the mother stay in the hospital after birth? _____

Describe your child in the first 6 months.

Easy baby No _____ Yes _____

Enjoys people No _____ Yes _____

Irritable No _____ Yes _____

Difficult to sooth No _____ Yes _____

Sleep/wake cycle poorly regulated No _____ Yes _____

Unusually quiet No _____ Yes _____

Unusually sick No _____ Yes _____

Feeding difficulties No _____ Yes _____

Strong reaction to light/sound/touch No _____ Yes _____

Colic No _____ Yes _____

Family History
Please list any medical or psychiatric illness that runs in your family _____
_____
_____
_____

Child's Early Development (specify age)

Sat without support _____
Crawled _____
Walked without support _____
Used single words _____
(other than mama or papa)
Used 2-3 word sentences _____
First began to sleep through the night _____
Daytime wetting stopped _____
Bed-wetting stopped _____
Bowel control _____

Child's Medical History

Child's primary care physician: _____
Address: _____
_____
Phone: _____

Date of last complete physical examination: _____

Does your child have any allergies (environmental, food, medication)? No ____ Yes ____
If yes, please list:
_____

_____
_____

_____
_____

Does your child take any medications? No ____ Yes ____
(Include vitamins, over the counter drugs, and herbal medications)

Name	Dosage	Frequency	Date began

Has your child ever been hospitalized for any reason? No ____ Yes ____

If yes, describe

Reason	Date	Place	Length of stay

Does your child have a current or past history of:

	No	Current	Past	List
Head injury				
Broken bones				
Surgeries				
Birth defects				
Poisoning (e.g.: lead)				
Heart problems				
Kidney problems				
Liver disease				
Lung disease				
Blood disease				
Cancer				
Seizure				
Other neurological problems (e.g.: headache)				
Genetic disorder				
Hormonal problems (e.g.: diabetes, thyroid)				
Skin problems				
Lyme disease				
Impaired Sight				
Impaired Hearing				
Speech Difficulty				
Sleeping Difficulty				
Eating Disorder				
Sleep Apnea				
Severe vomiting				
Choking events				
Other problems				

Childhood diseases (child's age in years)

Chicken pox No ____ Yes ____ Age _____
German measles/Rubella No ____ Yes ____ Age _____
Measles No ____ Yes ____ Age _____
Scarlet Fever No ____ Yes ____ Age _____
Whooping cough No ____ Yes ____ Age _____
Strep throat No ____ Yes ____ Age _____

Social development

Does your child make friends easily? No _____ Yes ____

Does your child have any difficulties interacting with other children? No _____ Yes _____

Does your child have any difficulties interacting with adults? No _____ Yes _____

Does your child have a "best friend?" No _____ Yes _____

Preschool/School History

Is your child attending preschool/school? No _____ Yes _____

If yes, name of school

_____

Child's current school grade

_____

Does your child attend any special classes or receive any special education services?

No _____ Yes _____ If yes, please name

_____

Has your child ever repeated a grade in school or been "held-back" for any reason?

No _____ Yes _____ If yes, explain

_____

Does your child have any learning or behavioral problems in school?

No _____ Yes _____ If yes, explain

_____

_____

_____

_____

_____

Sleep Habits

What time does your child generally go to bed? _____ pm/am

What time does your child generally wake up? _____ pm/am

On average, how many hours does your child sleep per night? _____hours

Does your child snore or seem to gasp for air during the night? No _____ Yes _____

Stressors

Is your child facing significant stressors at this time? No _____ Yes _____

If yes, please describe

_____

_____

_____

_____

_____

_____

_____

Is your family facing any significant stressors just now?

_____

_____
_____
_____
_____
_____
_____

Is there anything else you would like us to know that would assist us in understanding your child?

_____
_____
_____
_____
_____
_____
_____
_____
_____