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A psychological corporation

Diplomate of the American Board of Pediatric Neuropsychology
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CHILD INITIAL HISTORY

Name of Child:_____Date of Birth:_____
Parents' names: _____
Mom phone:_____ Mom email:_____
Dad phone:_____Dad email:_____
Emergency Contact (Name and Phone):_____
Current School:_____Grade: _____
Teacher/counselor (Name and Email0: _____
Who referred you? _____

Presenting problems (and when they began)?

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

Other issues/concerns?

_____
_____
_____
_____
_____

Goals of this consultation/assessment?

_____
_____
_____
_____

What are your child's strengths?

_____
_____

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HISTORY

1. Mother's health during pregnancy
   a. Planned pregnancy? Y/N Mother's age when child was born?_____
   b. Mother's health? _____
   c. Medications/alcohol/caffeine/tobacco?_____

2. Delivery
   a. Gestational age?_____Birth weight?_____
   b. Birth complications? Y/N_____ Fetal distress?Y/N _____
   c. APGAR score 1 minute?____At 5 minutes?____Time in NICU? Y/N_____

3. Infant's health
   a. Was baby nursed? Y /N If yes, when was (s)he weaned?_____
   b. Any feeding problems? Y/N _____
   c. Jaundice? Y/N Colic? Y /N Health problems? _____
   d. Easy or difficult baby (schedule/crying)?_____
   e. Sociability? _____ Activity level?_____

4. Milestones – the age at which your child:

   Smiled? _____Sat without support ?_____Crawled?_____Walked?_____

   Spoke first words? (other than mama/dada) _____Used phrases/sentences?_____

   Child's first language?_____Other languages? _____

   Prior physical/occupational/speech therapy?_____

   Age of toilet training: Bladder?_____Bowel?_____Level of difficulty?_____

5. Health Pediatrician: _____

   Specialists:_____

   a. Overall health? _____ Hearing? _____Vision?_____Colorblind? Y/N
   b. Fine motor coordination (writing/tying/using scissors)?_____
   c. Gross motor coordination (running/walking/sports)?_____

d. What exercise does your child get?_____

e. Is child clumsy accident prone? Y/N Frequent ear infections? Y/N _____

f. Childhood illnesses?_____

Seizures? Y/N Loss of consciousness? Y/N Broken bones? Y/N

Stitches? Y/N Poisoning? Y/N Head injury/TBI? Y/N Surgery? Y/N

Please explain:_____

g. Puberty status?_____

h. Alcohol or drug use?_____Level of certainty? _____

i. Sleeping problems Y/N?_____Snoring? Y/N Frequent nightmares? Y/N

j. Where does child sleep?_____Time screens go off:_____

k. Weekday bedtime?_____Wake up?_____Weekend bedtime? _____Wake up? _____

l. Current medications?_____Past meds?_____

m. Who prescribes? _____

n. Sensory hypersensitivities, past or present (please circle):

Tactile (sticky stuff, labels, itchy clothes, sock seams, waistbands)? Light?

Loud sounds? Quiet sounds? Smells? Food textures? Other?_____

o. Are there issues with food? Y/N_____

p. Current height :_____ Current weight:_____

6. <u>School history of child (name of school and child's performance)</u>

a. Preschool:_____

b. Elementary school:_____

c. Middle school:_____

d. High school:_____

e. Best subject(s)? _____Worst subject(s)?_____

f. Does your child have a 504/IEP? Y/N If so, what accommodations/services does (s)he receive?_____

g. What accommodations/ service would you like him/her to receive?_____

_____

h. Does (s)he have a tutor/educational therapist? Y/N If yes, who and how often?

_____

7. Family constellation and quality of relationships

Married/ Divorced/ Separated/ Widowed?_____Length of relationship?_____

Quality of relationship:_____

Other children? If so, please indicate names, ages and your child's relationship with each:

_____

_____

_____

Local family members?_____

Disciplinary practices used at home?_____

Time spent with child each day? _____Atmosphere at home:_____

Hours of TV/week? _____Video games?_____ Which ones:_____

Does (s) have a cellphone? Y/N TV in his/her room? Y/N Computer with internet? Y/N

Child's household responsibilities? _____

Does (s) need prompts? Y/N Does (s)he cooperate? Y/N Do a good job? Y/N

8. Social functioning

How's your child's social life? _____

What does (s)he like to do?_____

(For teens) Does (s)he drive?_____Work?_____

9. Psychiatric history of child

a. Traumas/major events in your child's life:_____

_____

b. Has (s)he had psychotherapy? Y/N If yes, when and with whom?

_____

_____

10. Parents' Educational/Work

Mother's education: _____

Father's education: _____

Parents' type of work? _____

11. Family handedness (left, right or ambidextrous)

Child? _____Siblings? _____

Father? _____Father's parents?_____ Father's Siblings? _____

Mother? _____Mother's parents?_____ Mothers Siblings? _____

12. Extended family (close relatives) medical history

Paternal _____

Maternal_____

13. Extended family psychiatric history - Close relatives with diagnosed or undiagnosed:

a. Aggression problems?_____
b. Attention problems?_____
c. Learning disabilities?_____
d. Psychosis/schizophrenia?_____
e. Physical sexual abuse?_____
f. Substance-abuse?_____
g. Tics/Tourette Syndrome?_____
h. Depression?_____
i. Anxiety?_____
j. Obsessions/Compulsions?_____
k. Eating Disorder?_____
l. Intellectual disability ("Mental Retardation")?_____
m. Bipolar disorder ("Manic Depression")?_____
n. Autism Spectrum/Asperger's Disorder?_____
o. Genetic disorder?_____
p. Personality disorder?_____

14. Supplementary information - anything else you want to include?_____

_____

_____

_____