# CHILD HISTORY FORM FOR TESTING

Child's Name: _____ Child's Age: _____ DOB: _____

What are the difficulties that led you to seek an evaluation for your child? _____

_____

_____

_____

What are your child's strengths? _____

_____

_____

_____

**FAMILY HISTORY**

Who is your child living with? _____

_____

What language(s) are spoken at home? _____

Parent(s)/Guardian(s): ❒ Single ❒Married ❒ Separated ❒ Divorced ❒ Widowed

Parent 1: ❒ Biological ❒ Foster/Adoptive ❒ Step

Parent 1 Name: _____

Parent 1 Age: _____ Parent 1 Occupation: _____

Parent 1 Phone #: _____ Parent 1 Email Address: _____

Parent 2: ❒ Biological ❒ Foster/Adoptive ❒ Step

Parent 2 Name: _____

Parent 2 Age: _____ Parent 2 Occupation: _____

Parent 2 Phone #: _____ Parent 2 Email Address: _____

Siblings? ❒ Yes ❒ No

If yes:

| | Biological, Adoptive, or Step? | Gender | Age |
|---|---|---|---|
| Sibling 1 | | | |
| Sibling 2 | | | |
| Sibling 3 | | | |
| Sibling 4 | | | |
| Sibling 5 | | | |

Please describe any developmental, learning (e.g., repeated grades, 504/IEP), behavioral, psychological, or medical difficulties amongst biological parents/siblings: _____

_____

_____

_____

_____

_____

_____

_____

Please describe any suspected or diagnosed developmental, learning, behavioral, psychological, or medical difficulties among extended biological family members (grandparents, uncles, aunts, cousins):

Maternal/mother's side

_____

_____

_____

_____

_____

_____

_____

Paternal/father's side

_____

_____

_____

_____

_____

_____

_____

**BIRTH & DEVELOPMENTAL HISTORY**

Any illnesses or complications during pregnancy? ❒Yes ❒ No

If yes, please explain: _____

_____

Any medications used during pregnancy? ❒ Yes ❒No

If yes, please list: _____

Any substances used during pregnancy? ❒ Yes ❒ No

❒Cigarettes: How many? _____ per ❒day ❒ week

❒ Alcohol: How many drinks? _____ per ❒ day ❒week ❒ month

❒ Nonprescription medications/drugs: Please list drug(s) and frequency of use:

_____

_____

Any complications during labor or delivery? ❒ Yes ❒ No

If yes, please explain: _____

_____

_____

Full Term? ❒ Yes ❒ No: _____weeks gestation

❒ Vaginal ❒ C-section

Birth weight: _____lbs. _____ oz. Length: _____in.

Did baby require special interventions or care (e.g., light therapy, NICU)? ❒ Yes ❒ No

If yes, please explain: _____

_____

_____

Any difficulties during infancy with: ❒ feeding ❒sleeping ❒ behavior ❒ other

If yes, please explain: _____

_____

Any major stressors during child's early development? ❒ Yes ❒ No

If yes, please explain: _____

_____

How old was your child when s/he:

Walked: _____ Used single words (other than "mama" or "dada"): _____

Potty trained (daytime): _____ Potty trained (nighttime): _____

Did anyone indicate concerns to you about your child's development? ❒ Yes ❒ No

If yes, please explain: _____

_____

Has your child ever received: ❒ Speech Therapy ❒ Physical Therapy ❒ Other

❒ Occupational Therapy ❒ Regional Center Services

If yes:

| Age(s) (e.g., from 8 to 10) | Duration (e.g., 30 min) | Frequency (e.g., 2x/week) | What was the treatment for? |
|---|---|---|---|
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**MEDICAL HISTORY**

Do you have concerns about your child's appetite or eating habits? ❒ Yes ❒ No

If yes, please describe: _____

_____

_____

_____

Does your child have difficulty with: ❒ falling asleep ❒ staying asleep ❒ nightmares
❒ night terrors ❒ sleeping in own bed

How many hours of sleep does your child get per night? _____

Does your child wear/use any adaptive devices (e.g., walker, hearing aids, glasses/contacts)? ❒ Yes ❒ No

If yes, please describe: _____

_____

_____

Date of last hearing test: _____ Were results normal? ❒ Yes ❒ No

Date of last vision test: _____ Were results normal? ❒ Yes ❒ No

Has your child ever had a head injury or lost consciousness (LOC)? ❒ Yes ❒ No

If yes, please describe, including duration of LOC and at what age: _____

_____

_____

Has your child ever been to the emergency room, been hospitalized, or had surgery? ❒ Yes ❒ No

If yes, please describe condition/injury/surgery, treatment, duration, and at what age:

_____

_____

_____

Please describe any other medical conditions, diagnoses, health considerations, and/or treatments:

_____

_____

_____

_____

_____

_____

Please list current and past medications or supplements:

| Name | Current Dose | Date Started | Date Ended | Side Effects? |
|---|---|---|---|---|
| | | | | |
| | | | | |
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| | | | | |

Any difficulties taking medication(s)? ❒ Yes ❒ No

**PSYCHIATRIC HISTORY**

Does your child have current difficulty with: ❒ attention ❒ hyperactivity

❒impulsivity ❒ aggression ❒ controlling behavior ❒ regulating emotions

❒ listening to adults ❒ risky behaviors ❒ making/keeping friends

How would you describe your child's mood, most days? _____

_____

Has your child ever received a psychological, neuropsychological or psychoeducational evaluation before? ❒ Yes ❒ No *(*If yes, please provide copy to examiner)*

If yes, please describe type of professional who did the assessment and age at evaluation:

_____

_____

Has your child ever been diagnosed with a mental health condition? ❒ Yes ❒ No

If yes:

| Diagnosis Name *(e.g., ADHD)* | Date Diagnosed | Who Diagnosed? *(psychiatrist, therapist, pediatrician, etc.)* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Is your child currently in therapy? ❒ Yes ❒ No

Has your child ever been in therapy? ❒ Yes ❒No

| Date Began | Date Ended | Frequency *(e.g., 50 min, 1x/week)* | What was the therapy for? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Has your child experienced any unusual, traumatic, or possibly stressful events, either in the past or recently? ❒ Yes ❒ No

If yes, please describe: _____

_____

_____

_____

**ACADEMIC HISTORY**

What grade is your child in? _____

Has your child ever: ❒ Skipped a grade: _____ ❒ Repeated a grade: _____

Does your child have current difficulty with:

❒ Reading fluency ❒ Reading comprehension ❒ Mathematics

❒Spelling ❒ Written expression ❒ Handwriting

Has your child ever had tutoring? ❒ Yes ❒ No

If yes, please describe in what subject areas and when (ages/grades): _____

_____

_____

_____

_____

Does your child have a 504 Plan or IEP? ❒ Yes ❒ No

If no, did your child have one previously? ❒ Yes ❒ No

*( *If yes, please provide copy of current/prior plans to examiner)*

Please list previous schools and grades attended at each, starting at preschool:

| School | Grades Attended | Grades Received *(e.g., A's-F's, 1-4's)* | Teacher(s) Have Concerns? *If yes, please describe.* |
|---|---|---|---|
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Please list your child's hobbies: _____

_____

_____

_____

Does your child have friends? Please describe how your child gets along with others and any concerns:

_____

_____

_____

_____

Has your child ever been employed? ❒ Yes ❒ No

If yes, please describe type of job, duration, and responsibilities: _____

_____

_____

_____