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CHILD HEALTH HISTORY FORM

Today's Date_____

Child's Name:		Full Home Address:	
Identified Gender:		Phone:	
Date of Birth:		Parent's Names:	
Current Age:		Referred by:	

Reason for Appointment (Describe concerns)

What specific questions would you like to have answered during the course of this evaluation?

Is the evaluation requested to provide information or evidence for legal proceedings of any kind? ____

When did your concerns first begin? Why? What are your present concerns?

What have you been told about your child's condition or the nature of his difficulties? What diagnoses has been given?

What is your child's <u>mental health</u> treatment history?

Type of Service (therapy, medication, hospital, partial program, residential)	Primary Treatment Goals	When it started	When it ended

Do/did the child's parents, grandparents, or siblings have learning difficulties, attentional problems, psychiatric problems, substance use issues, or neurological disorders? If so, please describe:

MEDICAL INFORMATION

What medications have been prescribed in the past?

What medications are currently being prescribed?

Name of Medication	Dosage	Prescribed/Monitored by:

Over-the-counter medications or treatments currently being used:

SLEEP: My child…

_____ Sleeps well
_____ Sleeps in his/her own bed
_____ Sleeps with parent
_____ Has difficulty falling asleep
_____ Has difficulty waking up
_____ Needs specific routines or items to be able to fall asleep
_____ Other:

____ Is very emotional right before bedtime
____ Often awakens in the middle of the night
____ Wets the bed
____ Has nightmares
____ Sleeps too much
____ Does not sleep enough
____ Other:

EATING HABITS: My child…

_____ Has a healthy diet
_____ Eats too much junk food
_____ Is overly sensitive to some types of food
_____ Is too picky of an eater
_____ Will try any food
_____ Is too preoccupied with food / calories
_____ Other:

____ Overeats (eats too much)
____ Binges (eats far too much)
____ Purges (intentionally vomits or over-exercises after eating)
____ Does not eat enough
____ Severely restricts calorie intake
____ Is too preoccupied with body image
____ Other:

EXERCISE: My child…

_____ Gets enough exercise
_____ Attends gym class at school
_____ Participates regularly in extracurricular sports
_____ Is part of a sports team
_____ Is part of a gym
_____ Identifies as an athlete
_____ Other:

____ Gets no exercise
____ Enjoys active play indoors and/or outdoors
____ Exercises on their own
____ Avoids all physical activity
____ Loves exercise
____ May play sports in college
____ Other:

Does the child wear eyeglasses?	Does the child wear a hearing aid?
Are there visual processing problems or other issues?	Are there audiological processing problems or other issues?
Date of last vision exam?	Date of last audiological exam?

Allergies

Has the child had the following illnesses and conditions (List date if known)

Measles	Chicken Pox	Ear Infections	Diabetes
Asthma	Pneumonia	Meningitis	Encephalitis
Convulsions/Seizures	Head Injuries	Staring Spells	Eating Problems
Broken Bones	Lead Poisoning	PANDAS	Lyme Disease
Other:			

Has your child ever been medically hospitalized? _____ If so, please provide the dates and reasons for hospitalization.

FAMILY INFORMATION

Parents' Marital Status	Single Separated Divorced Widowed Married ___ Years
Parents are:	Natural / Biological Foster Adoptive Guardians
Mother's Name	
Mother's Education/Occupation	
Mother's phone number	
Father's Name	
Father's Education/Occupation	
Father's phone number	

If Divorced or Separated (Custody Information)

Who has legal custody of child?	(please circle)	MOTHER	FATHER	BOTH
Who is the legal guardian?	(please circle)	MOTHER	FATHER	BOTH
Which parent has decision-making responsibilities for EDUCATION	(please circle)	MOTHER	FATHER	BOTH
Which parent has decision-making responsibilities for HEALTH	(please circle)	MOTHER	FATHER	BOTH
Which parent has decision-making responsibilities for RELIGION	(please circle)	MOTHER	FATHER	BOTH
Which parent has decision-making responsibilities for EXTRACURRICULAR ACTIVITIES	(please circle)	MOTHER	FATHER	BOTH
Which parent has decision-making responsibilities for CARETAKING	(please circle)	MOTHER	FATHER	BOTH

Please list all persons who live in the household, and their ages:

Name	Relationship	Age

EARLY DEVELOPMENT

Birth weight _____ Birth length _____

Child was: Full term Premature How many weeks premature? _____

List any significant problems during pregnancy or delivery

At what age did the child first:

Sit alone _____ Use single words _____

Stand alone _____ Speak in sentences _____

Walk alone _____ Toilet trained _____

Describe your child as an infant and toddler:

Did your child require Early Intervention Services? If so, please explain:

What other doctors, therapists, or professionals have been involved in your child's care?

Name of Provider	Service	How often	When it started	When it ended

EDUCATION INFORMATION

Age(s)	School (preschool, elementary, high)

ACADEMICS: My child…

_____ Loves school
_____ Gets good grades
_____ Is never in trouble
_____ Prefers these subjects?
_____ Skips (or tries to skip) school
_____ Is overly focused on good grades
_____ Takes advanced classes

____ Really dislikes school
____ Gets bad grades
____ Is often in trouble
____ Does not like these subjects:
____ Is anxious about school
____ Does not do homework
____ Has been suspended

Other

Name of Current School	
Current Grade	
Type of Classroom (In-Person, Hybrid, Remote, HomeSchool, etc)	
Is your child receiving special education services (504 Plan, IEP, etc)	Yes No Uncertain

If your child receives special school services, please describe:

Type of Special Education	When did it begin	Times Per Week	Length of Session

What other special educational services have been provided in the **past**?

Type of Special Education	When did it begin	When did it end

Has your child received private tutoring or educational services? Yes No If yes, please describe

Has your child ever repeated a grade? Yes No If yes, please describe

Has your child ever missed more than 10 days in a school year? Yes No If yes, please describe

SOCIAL FUNCTIONING

PEERS: My child…

_____ Has no problems making/keeping friends
_____ Has many friends
_____ Has one or two close friends
_____ Hangs out with good kids
_____ Spends time IN PERSON with friends
_____ Uses good judgment with peers
_____ Prefers same-age peers

____ Has difficulty making/keeping friends
____ Has no friends
____ Wants to have more friends
____ Hangs out with "bad" kids
____ Spends time ONLINE with friends
____ Uses bad judgment with peers
____ Prefers younger/older peers

Other

ADULTS: My child…

_____ Is respectful towards adults	____ Is well-liked by adults
_____ Follows rules and directives	____ Is an example to other kids
_____ Is disrespectful of authority	____ Gets in trouble a lot
Respects men more than women	Respects women more than men

Other

Has your child recently had any major changes or stressors in his/her life (e.g., divorce, loss of pet, friend moved, new school, move, change in academic/social/athletic status, bullying, etc)? If so, please describe.

Have COVID-19 safety measures (social distancing, remote learning, quarantine, scary news, etc) affected your child? How? Are there new problems/concerns that have arisen since March 2020?

Please share additional comments or provide other information that will help us to understand your child and your concerns.