Center for Psychology And Learning

Assessment, Therapy & Consultation

Child Background History Form

Name of child: _____ Birthdate: ___/___/___

Home address: _____

_____

Home phone: _____

Caregiver's name: _____ Relationship _____

Educational level: _____

Occupation: _____

Cell phone: _____ Work phone: _____

Email: _____

Caregiver's name: _____ Relationship _____

Educational level: _____

Occupation: _____

Cell phone: _____ Work phone: _____

Email: _____

Who referred you for this evaluation? _____

Briefly indicate the reasons for the present evaluation:

_____

_____

_____

_____

Circumstances/factors you think are important regarding this decision:

_____

_____

_____

_____

Are you in agreement with this referral? Yes/No (If no please explain) _____

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PREGNANCY:

1. Was this child adopted? yes ____ (skip to Early History Section)
no ____ (complete below)

2. Age of mother at delivery _____

3. Age of father at delivery _____

4. How much did your child weigh at birth? _____pounds _____ounces

5. Length of Pregnancy _____

6. Did you experience any prenatal complications? yes ____ no____
If yes, please describe: _____
_____

7. Did you take any medications during pregnancy? yes ____ no ____
If yes, what medications did you take, for what reason: _____
_____

8. During your pregnancy with this child, did you use any of the following?

	Yes	No	Amount
Alcohol			
Tobacco			
Cocaine			
Other drugs			

BIRTH HISTORY:

	Yes	No	If yes, please describe
Was the birth a cesarean section?			
Was labor induced?			
Were you given medication during labor?			
Was anesthesia used during labor?			
Was this a multiple birth?			
Was the baby born head-first?			
Were forceps used during delivery?			
Did your baby have any breathing problems?			
Was your baby born with cord wrapped around neck?			
Did your baby have low Apgar scores?			
Did your baby require incubation?			
Did your baby receive oxygen?			
Did your baby require phototherapy? (jaundice)			
Was your baby colicky?			
Did this baby have any feeding problems?			
Was the baby normally active?			
Did the baby fail to grow normally or gain weight?			
Was this baby different in any way from brothers or sisters?			

EARLY HISTORY:

1. At approximately what age did this child:

	Age (in months)
Sit alone	
Walk alone	
Speak 1st words	
First put words together meaningfully	
Talk in complete sentences	
Become toilet trained for bladder	
Become toilet trained for bowel	

2. Does your child have any speech or language problems? yes____ no____
If yes, please describe:_____
_____

3. Is English the child's first language? yes____ no____
If no, what is child's first language?_____
How old was your child when s/he learned to speak English?_____

MEDICAL HISTORY

1. Has your child had any of the following?

	Yes	No	Age	If yes, Explanation
Head Injury				
Loss of consciousness				
Meningitis				
Encephalitis				
Seizures				
High Fever				
Strep Throat				
Ear Infections				
Myringotomy tubes (tubes in ears)				
Vision Problems				
Hearing Problems				
Heart Disease				
Asthma				
Chicken Pox				
Mumps				
German Measles (rubella)				
Measles (rubeola)				
Other serious illness:				

2. Is your child currently taking any medications? yes____ no____If yes:

Medication	Dosage	Dates	Reason	Prescribed by

3. Has your child had any of the following tests?

	Yes	No	Date	What was the result?
Eye Exam				
Hearing Test				
EEG				
MRI				
CT Scan				

4. Has your child ever been hospitalized? yes____ no____

If yes:

Reason for Hospitalization	Age of Child	Length of Stay

FAMILY MEDICAL HISTORY

1. Is there anyone in your immediate or extended family who has (or had) any of the following:

	Yes	No	If yes, who (relationship to child)
Learning problems			
Neurological disease			
Seizures (epilepsy)			
Intellectual Disablity			
Autism/Developmental Disorder			
Attentional problems			
Behavioral problems			
Alcohol/Substance Abuse			
Depression			
Manic-Depression/Bipolar			
Anxiety Disorder			
Obsessive-Compulsive Disorder			
Schizophrenia			
Other psychiatric problems			
Diabetes			
Cancer			
High blood pressure			
Heart disease			
Alzheimer's Disease/Dementia			
Other disease/health problem that runs in family			

SOCIAL/EMOTIONAL/BEHAVIORAL HISTORY

1. Are the parents: _____married date:_____
_____domestic partners date:_____
_____separated date:_____

_____divorced date:_____
_____never married

2. If parents are divorced, what are the custody arrangements: _____
_____

3. If either or both parent(s) have remarried, please fill in the following section regarding step-parents or additional caregivers:

Name:	_____	_____
Relationship:	_____	_____
Age:	_____	_____
Education:	_____	_____
Occupation:	_____	_____

4. Does your child have any siblings? no____ yes____ (please complete below)

Name:			
Age:			
Grades repeated:			
Learning or Emotional Difficulties:			

5. Who lives with your child? _____

6. Would you describe your child as:

	Yes	No	If yes, please describe
Shy			
Well Behaved			
Impulsive			
Clumsy			
Immature			
Stubborn			
More active than other children			

7. Has your child received any psychological or psychiatric treatment? yes____ no____

If yes, please complete below:

Provider	Primary reason for seeking treatment	Dates

8. Please indicate any past evaluation and treatment diagnoses _____

9. How would you describe your child's personality?
_____
_____
_____

10. How does your child get along with other children?
_____

11. Do you have any concern about your child's behavior?

12. Do you have any concern about your child's emotional well-being?

13. What forms of discipline do you use with your child?

Are they successful?

14. Please describe any family stressors or stressful life events:

15. Please describe the best things about your child:

16. Does your child have or did your child ever have:

	Yes	No	If yes, please list approx. age and a brief description of the problem
Temper tantrums			
Sleep problems			
Nightmares			
Blank Spells/Staring Spells			
Falling Spells			
Sensory Integration Issues			
Poor Handwriting			
Head Banging			
Toe Walking			
Thumb Sucking			
Tics or Twitching			
Repetitive Motions			
Difficulty with transitions			
Difficulty staying with an activity			
Bedwetting after age 5			

Eating paper, paint, etc.			
Emotional Problems			
Adjustment Problems			
Behavioral Problems			

SCHOOL HISTORY

1. At what age did your child begin school? _____

2. What grade is your child currently in? _____

3. What school does your child currently attend? _____

School Address: _____
_____
_____

4. What is (are) the name of your child's teacher(s)? _____
_____
_____

5. Please list all schools your child has attended:

Grade(s)	Name of School	Years Attended (ie. 1996-1997)

6. Within the past year has the school reported problems with:

	Yes	No	Indicate nature of problem
Reading			
Spelling			
Writing			
Arithmetic			
Behavior			
Social Adjustment			
Attention Span			
Following Directions			

7. Does your child like school? yes____ no____

8. During the past school year, how many days of school did your child miss?_____

9. Briefly describe your child's school experiences with regard to academic performance:
_____
_____
_____

10. What kinds of grades does your child typically earn?_____

11. Briefly describe your child's school experiences with regard to behavior/attention:

_____
_____
_____

12. If your child has had any difficulties in school (academic or behavioral), in which grade did these problems start?_____

13. Does your child have any difficulties with completion of homework? Please describe:

_____
_____
_____

14. Please describe your child's hobbies, sports, or involvement in clubs/groups:

_____
_____
_____

15. Has your child:

	Yes	No	Grade(s)	Description
Been in accelerated classes or classes for the gifted?				
Been retained in any grade?				
Received tutoring?				
Received resource support?				
Been in a self-contained Special education classroom?				

14. Is your child currently eligible for special education services? yes____ no____
If yes, is it because of (check all that apply)

Specific Learning Disability _____
Intellectual Disability _____
Speech/Language Impairment _____
Emotional/Behavioral Disability _____
Other Health Impaired _____

15. Please specify any special education support your child currently is receiving:

	What grade (s)?	Who provides service?
Reading		
Written Language		
Math		
Speech/language		
Occupational Therapy		
Physical Therapy		

Person completing form: _____
Signature: _____ Date: _____
Relationship to child: _____

PLEASE ENCLOSE ANY PREVIOUS REPORTS TO MAXIMIZE THE BENEFITS OF THIS EVALUATION AND TO ASSURE THAT THE SAME TESTS ARE NOT GIVEN REPEATEDLY, POSSIBLY INVALIDATING RESULTS.