Childhood History Form

unlocking potential

Contact Information

Child's Name:

Birth Date: | Age: | Sex: | Ethnicity:

Home Address:

City: | State/Province: | Zip/Postal Code:

Home Phone: | Cell Phone 1 (parent): | Cell Phone 2 (parent):

Child's School Name and Address:

Grade: | Special Placement (if any):

Child is presently living with:

- ☐ Birth Mother
- ☐ Birth Father
- ☐ Stepmother
- ☐ Stepfather
- ☐ Adoptive Mother
- ☐ Adoptive Father
- ☐ Foster Mother
- ☐ Foster Father
- ☐ Other (specify):

Nonresidential adults involved with this child on a regular basis:

Source of referral:

Briefly describe your main concern regarding this child:

Birth Parents' Information

Mother:

Occupation:

Business Phone:

Age:

Age at time of pregnancy with patient:

Highest grade completed:

Please describe any history of . . .

learning difficulties:

attention difficulties:

behavior difficulties:

emotional/psychiatric difficulties:

medical difficulties:

prescriptions used for past or present psychiatric/psychological difficulties:

Have any of the birth mother's blood relatives experienced difficulties similar to those your child is experiencing? If so, describe:

Father:

Occupation:

Business Phone:

Age:

Age at time of pregnancy with patient:

Highest grade completed:

Please describe any history of . . .

learning difficulties:

attention difficulties:

behavior difficulties:

emotional/psychiatric difficulties:

medical difficulties:

prescriptions used for past or present psychiatric/psychological difficulties:

Have any of the birth father's blood relatives experienced difficulties similar to those your child is experiencing? If so, describe:

Child's Siblings

	Name	*Age*	*Medical, Social, Emotional, or School Problems*
1.			
2.			
3.			
4.			
5.			
6.			

Pregnancy Complications

Excessive vomiting ..... Yes ◯ No ◯

Hospitalization required..... Yes ◯ No ◯

Excessive staining/blood loss ..... Yes ◯ No ◯

Threatened miscarriage..... Yes ◯ No ◯

Infection(s) (specify):

Toxemia..... Yes ◯ No ◯

Operation(s) (specify):

Other illness(es) (specify):

Smoking during pregnancy..... Yes ◯ No ◯

Number of cigarettes per day:

Alcoholic consumption during pregnancy..... Yes ◯ No ◯

Describe if beyond an occasional drink:

Medications taken during pregnancy:

Duration of pregnancy (weeks):

Delivery

Type of labor:

☐ Spontaneous ☐ Induced Delivery duration (hrs.):

Type of delivery:

☐ Normal ☐ Breech ☐ Caesarean

Complications:

☐ Cord around neck ☐ Hemorrhage ☐ Infant injured during delivery ☐ Other (specify):

Birth weight:

Postdelivery Period

☐ Jaundice ☐ Cyanosis ☐ Incubator care ☐ Infection (specify):

Number of days infant was in the hospital after delivery:

Infancy Period

Were any of the following present—to a significant degree—during the first few years of life? If so, describe:

Did not enjoy cuddling:

Was not calmed by being held or stroked:

Difficult to comfort:

Colic:

Excessive restlessness:

Excessive irritability:

Diminished sleep:

Frequent head banging:

Difficulty nursing:

Constantly into everything:

Temperament

Please describe how the following behaviors appeared during your child's infancy and toddlerhood:

Activity Level: How active has your child been from an early age?

Distractibility: How easily was your child's attention diverted?

Adaptability: How well did your child deal with transition and change?

Approach/Withdrawal: How well did your child respond to new things (e.g., places, people, food)?

Intensity: How aware were others of your child's feelings?

Mood: What was your child's basic mood?

Regularity: How predictable was your child in patterns of sleep, appetite, etc.?

Persistence and Attention: How well was your child able to persist in attaining a goal and attending to one activity for a period of time?

Sensory Threshold: Was your child over- or under-sensitive to light, sound, textures?

Medical History

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information:

Childhood diseases (describe any complications):

Operations:

Hospitalization for illness:

Head injuries:

Convulsions:

with fever ◯ without fever ◯

Coma:

Persistent, high fevers:

Eye problems:

Tics (e.g., eye blinking, sniffing, any repetitive, nonpurposeful movements):

Ear problems:

Allergies or asthma:

Poisoning:

Sleep:

- Does your child settle down to sleep?
- Sleep through the night without disruption?
- Experience nightmares, night terrors, sleepwalking, sleep talking?
- Is your child a very restless sleeper?
- Does your child snore?

Appetite:

- Any recent changes in appetite in the last six months?

Present Medical Status

Height:

Weight:

Present illnesses for which the child is being treated:

Medications the child is taking?

Developmental Milestones

When did your child reach the following developmental milestones?

Smiled	Early ◯	Normal ◯	Late ◯
Sat without support	Early ◯	Normal ◯	Late ◯
Crawled	Early ◯	Normal ◯	Late ◯
Stood without support	Early ◯	Normal ◯	Late ◯
Walked without assistance	Early ◯	Normal ◯	Late ◯
Spoke first words	Early ◯	Normal ◯	Late ◯
Said phrases	Early ◯	Normal ◯	Late ◯
Said sentences	Early ◯	Normal ◯	Late ◯
Bladder trained, day	Early ◯	Normal ◯	Late ◯
Bladder trained, night	Early ◯	Normal ◯	Late ◯
Bowel trained, day	Early ◯	Normal ◯	Late ◯
Bowel trained, night	Early ◯	Normal ◯	Late ◯
Rode tricycle	Early ◯	Normal ◯	Late ◯
Rode bicycle (without training wheels)	Early ◯	Normal ◯	Late ◯
Buttoned clothing	Early ◯	Normal ◯	Late ◯
Tied shoelaces	Early ◯	Normal ◯	Late ◯
Named colors	Early ◯	Normal ◯	Late ◯
Named coins	Early ◯	Normal ◯	Late ◯
Said alphabet in order	Early ◯	Normal ◯	Late ◯
Began to read	Early ◯	Normal ◯	Late ◯

Social Behavior

Does your child . . .

talk excessively about favorite topics that hold limited interest for others?	Yes ◯	No ◯
use words or phrases repetitively?	Yes ◯	No ◯
not understand jokes?	Yes ◯	No ◯
interpret conversations literally?	Yes ◯	No ◯
frequently ask irrelevant questions?	Yes ◯	No ◯
experience difficulty with conversational skills?	Yes ◯	No ◯
avoid or limit eye contact?	Yes ◯	No ◯
exhibit limited facial expression?	Yes ◯	No ◯
not appear to understand basic social behavior?	Yes ◯	No ◯

miss social cues? ..... Yes ◯ No ◯

exhibit a strong negative reaction to change in routine? ..... Yes ◯ No ◯

engage in obsessive behavior? ..... Yes ◯ No ◯

display an extreme or obsessive interest in a narrow subject? ..... Yes ◯ No ◯

lack organizational skills? ..... Yes ◯ No ◯

appears passively inattentive? ..... Yes ◯ No ◯

overreact to normal sensory information? ..... Yes ◯ No ◯

limit self to certain clothing or foods? ..... Yes ◯ No ◯

appear clumsy or uncoordinated? ..... Yes ◯ No ◯

Coordination

Rate your child on the following skills:

Walking ..... Good ◯ Average ◯ Poor ◯

Running ..... Good ◯ Average ◯ Poor ◯

Throwing ..... Good ◯ Average ◯ Poor ◯

Catching ..... Good ◯ Average ◯ Poor ◯

Shoelace tying ..... Good ◯ Average ◯ Poor ◯

Buttoning ..... Good ◯ Average ◯ Poor ◯

Writing ..... Good ◯ Average ◯ Poor ◯

Athletic abilities ..... Good ◯ Average ◯ Poor ◯

Number of accidents compared to other children ..... Good ◯ Average ◯ Poor ◯

Comprehension and Understanding

Do you believe your child understands directions and situations as well as other children the same age? If not, why?

How would you rate your child's overall level of intelligence compared to other children? Above Average ◯ Average ◯ Below Average ◯

School History

Were you concerned about your child's ability to succeed in kindergarten? If so, please explain:

Rate your child's school experiences related to academic learning:

Preschool..... Good ◯ Average ◯ Poor ◯

Kindergarten..... Good ◯ Average ◯ Poor ◯

Current grade..... Good ◯ Average ◯ Poor ◯

To the best of your knowledge, at what grade level is your child functioning?

Reading: Spelling: Arithmetic:

Has your child ever had to repeat a grade? If so, when?

Has your child been formally evaluated for learning problems or a gifted and talented program?

Present class placement:

Regular class ◯ Special class (if so, specify): ◯

Kinds of special counseling or remedial work your child is currently receiving:

Briefly describe any academic school problems:

Rate your child's school experiences related to behavior:

Preschool..... Good ◯ Average ◯ Poor ◯

Kindergarten..... Good ◯ Average ◯ Poor ◯

Current grade..... Good ◯ Average ◯ Poor ◯

As best you can recall, please use the following space to provide a general description of your child's school progress in each grade. Please use the Additional Remarks section if you need more space.

Does your child's teacher report any of the following as significant classroom problems?

- Doesn't sit still in their seat ☐
- Frequently gets up and walks around the classroom ☐
- Shouts out; doesn't wait to be called on ☐
- Won't wait their turn ☐
- Doesn't cooperate well in group activities ☐
- Typically does better in a one-to-one relationship ☐
- Doesn't respect the rights of others ☐
- Doesn't pay attention during storytelling or show-and-tell ☐

Briefly describe any **other** classroom behavioral problems:

Peer Relationships

Does your child seek friendships with peers? Yes ◯ No ◯

Is your child sought by peers for friendship? Yes ◯ No ◯

Does your child play with children primarily the same age? Yes ◯ No ◯ Younger? ◯ Older? ◯

Briefly describe any problems your child may have with peers:

Home Behavior

All children exhibit, to some degree, the behaviors listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children the same age.

- Fidgets with hands or feet, or squirms in seat Yes ◯ No ◯
- Has difficulty remaining seated when required to do so Yes ◯ No ◯
- Easily distracted by extraneous stimulation Yes ◯ No ◯
- Has difficulty awaiting turn in games or group situations Yes ◯ No ◯
- Blurts out answers to questions before they have been completed Yes ◯ No ◯
- Has problems following through with instructions (usually not due to opposition or failure to comprehend) Yes ◯ No ◯
- Has difficulty paying attention during tasks or play activities Yes ◯ No ◯
- Shifts from one uncompleted activity to another Yes ◯ No ◯
- Has difficulty playing quietly Yes ◯ No ◯
- Often talks excessively Yes ◯ No ◯

Interrupts or intrudes on others (often not purposeful or planned but impulsive) ..... Yes ◯ No ◯

Does not appear to listen to what is being said ..... Yes ◯ No ◯

Loses things necessary for tasks or activities at home ..... Yes ◯ No ◯

Boundless energy and poor judgment ..... Yes ◯ No ◯

Impulsivity (poor self-control) ..... Yes ◯ No ◯

History of temper tantrums ..... Yes ◯ No ◯

Temper outbursts ..... Yes ◯ No ◯

Frustrates easily ..... Yes ◯ No ◯

Sloppy table manners ..... Yes ◯ No ◯

Sudden outbursts of physical abuse of other children ..... Yes ◯ No ◯

Overly anxious/worried ..... Yes ◯ No ◯

Low mood/withdrawn ..... Yes ◯ No ◯

Severe sibling rivalry ..... Yes ◯ No ◯

Sticks with activities to completion ..... Yes ◯ No ◯

If yes, what?:

Seems to be driven by a motor ..... Yes ◯ No ◯

Wears out shoes more frequently than siblings ..... Yes ◯ No ◯

Excessive number of accidents ..... Yes ◯ No ◯

Doesn't seem to learn from experience ..... Yes ◯ No ◯

Poor memory ..... Yes ◯ No ◯

A "different child" ..... Yes ◯ No ◯

To the best of your knowledge, has your child . . .

consumed alcohol? ..... Yes ◯ No ◯

taken illegal drugs? ..... Yes ◯ No ◯

violated the law? ..... Yes ◯ No ◯

destroyed property? ..... Yes ◯ No ◯

How well does your child work for a short-term reward?

How well does your child work for a long-term reward?

Does your child create more problems than their siblings, either purposeful or nonpurposeful, within the home setting? ..... Yes ◯ No ◯

Does your child have difficulty benefitting from experience? ..... Yes ◯ No ◯

Types of discipline you use with your child:

Do both parents agree on disciplinary practices? ..... Yes ◯ No ◯

Is there a particular form of discipline that has proven effective?

Have you participated in a parenting class or obtained other forms of information concerning discipline and behavior management?

Interests and Accomplishments

What are your child's main hobbies and interests?

What are your child's areas of greatest accomplishment?

What does your child enjoy doing most?

What does your child dislike doing most?

What do you like about your child?

Indicate how many hours per day your child spends on the following activities:

Watching TV: Playing video games: On the Internet or cell phone:

Does your child experience problems with . . .

planning (the ability to strategize, self-monitor, form a plan, follow a plan, and change plans when needed)?..... Yes ◯ No ◯

simultaneous processing (the ability to reason and solve problems)?..... Yes ◯ No ◯

attention (attention to relevant detail, knowing what to pay attention to and when)? ..... Yes ◯ No ◯

succession (working with information in sequence such as memorizing a phone number, address, and alphabet)?..... Yes ◯ No ◯

association (making verbal and visual associations such as learning the names of letters, colors, and shapes)? ..... Yes ◯ No ◯

Past Diagnoses

Please check box if your child has been diagnosed with and/or treated for:

ADHD—inattentive presentation..... Diagnosed ☐ Treated ☐

ADHD—hyperactive-impulsive presentation..... Diagnosed ☐ Treated ☐

ADHD—combined presentation..... Diagnosed ☐ Treated ☐

Autism spectrum disorder..... Diagnosed ☐ Treated ☐

Social pragmatic communication disorder..... Diagnosed ☐ Treated ☐

Asperger's disorder	Diagnosed ☐	Treated ☐
Pervasive developmental disorder—not otherwise specified	Diagnosed ☐	Treated ☐
Oppositional defiant disorder	Diagnosed ☐	Treated ☐
Conduct disorder	Diagnosed ☐	Treated ☐
Generalized anxiety disorder	Diagnosed ☐	Treated ☐
Separation anxiety disorder	Diagnosed ☐	Treated ☐
Specific phobia	Diagnosed ☐	Treated ☐
Posttraumatic stress disorder	Diagnosed ☐	Treated ☐
Obsessive/compulsive disorder	Diagnosed ☐	Treated ☐
Tics	Diagnosed ☐	Treated ☐
Bipolar disorder	Diagnosed ☐	Treated ☐
Elective mutism	Diagnosed ☐	Treated ☐
Anorexia or bulimia	Diagnosed ☐	Treated ☐
Enuresis or encopresis	Diagnosed ☐	Treated ☐
Substance use disorder	Diagnosed ☐	Treated ☐

Provide name, phone number, email, and address of any other professional consulted (including the time frame of services received):

1.

2.

3.

4.

5.

Additional Remarks

Please write any additional remarks you may wish to make regarding your child.

Source: *Childhood History Form*. (1995). ©Sam Goldstein, PhD, clinical director of the Neurology, Learning, and Behavior Center in Salt Lake City, Utah.
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