HEALTH HISTORY

CHILD PATIENT

Name of Patient		Date	
Gender	Male ☐ Female ☐	Date of Birth / /	Age
Address			
Address		Phone Number	
Parent(s) Name			
Education Level Attained			Age
Parent(s) Name			
Education Level Attained			Age
Legal Guardian			
Person completing form			
Email			

FAMILY HISTORY

Family history can often be helpful in understanding a child's problems.
Please check any box that applies:

Has anyone in the family had:	***Siblings***	***Parents***	***Extended Family***
Motor problems			
Reading problems			
Speech/language problems			
School/learning problems			
Alcohol/drug problems			
Anxiety, depression, other psychological disorders			
Seizures/epilepsy			
Attention problems/hyperactivity			

Please list all family members (in or out of house) and other people currently in the house:

NAME	RELATIONSHIP	AGE	CURRENTLY IN HOUSE?

Parents are: Married ☐ Living together ☐ Divorced ☐ Separated ☐ Widowed ☐

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BIRTH HISTORY

How would you describe your pregnancy? _____

Did you experience complications? If so, please list: Example, Gestational Diabetes, Pre-eclampsia, high blood pressure, etc? _____

Did you receive any vaccinations while pregnant? ___Yes ___No

Was any dental work done while pregnant? ___Yes ___No

If yes, what? _____

Did any stressful situations occur during pregnancy? Example, death in the family, loss of a spouse's job, separation, etc?

_____

Please check what best describes your labor and birth of your child?

___Normal (no interventions) ___Rh Factor problems ___Caesarian section

___Mother was sick ___Long/difficult labor ___Forceps or suction used

___Complications during birth ___Epidural given ___Induced

___Problems with the umbilical cord ___Facial/breech/brow presentation

Did your child have any of the following problems at birth?

___Difficulty breathing ___Health problems ___Infection

___Low birth weight ___Problems with bones/joints ___Jaundice

___Fever or seizures ___Required blood transfusions ___Intensive care

___Bruised anywhere ___Nerve problems

Does this/did this child have any birth defects? ___Yes ___No

If yes, what? _____

Describe what your child's temperament was like as an infant.

___Difficult ___Calm ___Sleepy ___Hyper sensitive

___Irritable ___Active ___Easily scared ___Frequent crying

___Sociable ___Cranky ___Happy ___Alert

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During the first twelve months, was this child:

Difficult to get to sleep	___Yes ___No	Irritable	___Yes ___No
Difficult to be put on a schedule	___Yes ___No	Alert	___Yes ___No
Easy to comfort	___Yes ___No	Affectionate	___Yes ___No
Overactive/in constant motion	___Yes ___No	Sociable	___Yes ___No

Was the child breast fed? ___Yes ___No For how long? _____

When was solid food introduced? _____

Was there any evidence of food intolerances? ___Yes ___No

If so, to what? _____

DEVELOPMENTAL HISTORY

How old was the child when (s)he:

	Average Age	Approximate Age	If not sure, please estimate		
Sat	4-7 mos		Early	Average	Late
Walked	12-17 mos		Early	Average	Late
Toilet Trained	18-36 mos		Early	Average	Late
Said first words	12-17 mos		Early	Average	Late
Began using sentences	36-60 mos		Early	Average	Late

SPEECH AND LANGUAGE

Has his/her hearing ever been tested?	___Yes	___No
Does this child have a history of frequent ear infections?	___Yes	___No
Has (s)he ever had tubes placed in her/his ears?	___Yes	___No
Last hearing/audiology evaluation: PLACE_____	DATE: _____	

Does this child have:

Any speech problems/difficulty speaking?	___Yes	___No
Have any trouble understanding what is being said to him/her?	___Yes	___No
Has (s)he ever had a Speech and Language Evaluation?	___Yes	___No
If yes, where? _____	When? _____	
RESULTS _____		
Has (s)he ever had Speech/Language Therapy?	___Yes	___No
Is (s)he currently receiving Speech/Language Therapy?	___Yes	___No

If yes, where? _____

Frequency: _____

MOTOR SKILLS

Does this child have fine motor problems (writing, drawing)? ___Yes ___No

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Has (s)he ever had Occupational Therapy (OT) evaluation? ___Yes ___No
Is (s)he currently receiving OT services? ___Yes ___No
If yes, where? _____ Frequency: _____
Does (s)he have any gross motor problems (walking, running)? ___Yes ___No
Has (s)he ever had a Physical Therapy (PT) evaluation? ___Yes ___No
Is (s)he currently receiving PT services? ___Yes ___No
If yes, where? _____ Frequency: _____
Does this child use any adaptive devices (braces)? ___Yes ___No
If yes, please describe:
_____
_____

VISION

Has this child ever been to an eye doctor? ___Yes ___No
Most recent date: _____
Does this child wear glasses? ___Yes ___No
If yes, why? _____
Has this child ever been assessed for / diagnosed with:
___Binocular Vision ___Convergence Insufficiency
___Other Convergence Issues ___Fixation Issues

IMPORTANT: if a child wears glasses, please bring them to the appointment

MEDICAL HISTORY

Is the child regularly checked by the following:
___Medical Doctor ___Chiropractor ___Osteopath
___Naturopath ___Dentist ___Other

Has the child had the following childhood or other diseases?

___Bronchitis ___Allergies ___Abdominal Pains ___Pertussis ___Scarlet Fever
___Bed Wetting ___Asthma ___Croup ___Measles ___Meningitis
___Seizures ___Chronic Colds ___Colic ___Mumps ___Rubella
___Chicken Pox ___Ear Infections

Does this child have/had braces on his/her teeth? ___Yes ___No

Does this child have any amalgam fillings? How many? ___Yes ___No
How many continuous hours is the child sleeping? _____
Is she/he well rested in the morning? ___Yes ___No
Does the child suffer from sleeping difficulties? ___Yes ___No
Does the child have problems with food/eating? ___Yes ___No
Is the child a fussy eater? ___Yes ___No
Does the child have issues with hygiene/cleanliness? ___Yes ___No
Does the child complain of any ongoing physical pains? (headaches, tummy aches, Muscle/joint aches, or growing pains) ___Yes ___No
Does the child suffer from dry skin, dandruff, hard skin on elbows,
bumps on the outside of the arms, cracked heels, excessive thirst/urination?
Has this child received vaccines? ___Yes ___No
If yes, please list:
_____
_____
Were there any of the following adverse reactions noticed? ___Yes ___No ___
___Inconsolable crying ___High fever ___Sleep disruptions afterward
___Lethargy ___Irritability ___Developed allergies
How many courses of antibiotics has this child received?
_____
Has this child taken any other prescription medication in the past? ___Yes ___No
If yes, what were they?
_____
Is the child exposed to a toxic environment (including passive smoking)? ___Yes ___No
Has the child had any serious falls, physical traumas, or physical injuries?
Please list:
_____
_____

SCHOOL HISTORY

Does the child like/enjoy school? ___Yes ___No
If not, why not?
_____
_____
_____
_____

HEALTH HISTORY

CHILD PATIENT

Beside each subject, indicate whether it is an academic Strength or Weakness of your child:

English	S___	W___	Math	S___	W___	Music	S___	W___
History	S___	W___	Science	S___	W___	Creative Writing	S___	W___
Gym/Sports	S___	W___	Other languages	S___	W___	Other:	S___	W___
Art	S___	W___						

Beside each domain, indicate whether it seems a Strength or a Weakness in your child:

Vocabulary and Expression	S___	W___	Reading quickly	S___ W___
Creative Writing	S___	W___	Memorizing	S___ W___
Getting assignments done on time	S___	W___	Spelling	S___ W___
Understanding concepts	S___	W___	Planning	S___ W___
Reading comprehension	S___	W___	Concentration	S___ W___
"Good" behavior	S___	W___	Handwriting	S___ W___
Test Preparation	S___	W___	Organization	S___ W___

Is getting homework done a struggle? ___Yes ___No

BEHAVIOR/MENTAL HEALTH

Describe any sports or activities the child is involved in: _____
_____
_____
_____

Indicate how many hours a week of "screen time" the child uses:

Computer _____ Smart Device (phone, iPad, etc.) _____
Computer games (DS, etc.) _____ Television _____

Describe the child's family relationships; with parents and siblings: _____

Does your child have many friends? ___Yes ___No

Does the child appear to excel at or struggle to build relationships with their peers?
___Excel ___Struggle ___Neither

If they struggle, why do you think that is? _____
_____

What problems does the child have with peers, if any?

___None	___Bragging to peers	___Being teased
___Being physically attacked	___Rejected by peers	___Overly physically affectionate
___Being bullied	___Jealous of peers	

Does this child have self-esteem issues? ___Yes ___No

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Which of the following has the child experienced in the last 12 months?

___Serious illness/injury in immediate family
___Parents separation/divorce
___Birth of a sibling
___None
___Change of school
___Move to a new home
___ Death of immediate family member
___Other: _____
___Mother pregnant
___Parent losing a job

Do you feel that this child exhibits any of the following symptoms more often than is typical for a child of his/her age? (Please check any that apply)

___Often touchy/easily annoyed
___Often defies adult rules
___Often angry/resentful
___Often argues with adults
___Often looses temper
___Blames others for mistakes
___Deliberately annoys
___Often spiteful/vindictive
___Refuses to go to school
___Repeated nightmares
___Unusual fears
___Panic attacks
___Self-conscious/clings
___Excessive need for reassurance
___Self-injurious behavior
___Worry of future events
___Repeats certain actions
___Somatic complaints (headache/stomach)
___Difficulty maintaining friendships
___Often bullies/threatens
___Initiates physical fights
___Ever been arrested
___Physically cruel to others
___Physically cruel to animals
___Motor or vocal tics
___Destroys property
___Deliberately sets fires
___Lies often
___Steals
___Has run away
___Extreme mood swings
___Does not show emotions
___Overreacts to touch/noise
___Strange to bizarre ideas
___Used drugs in the past
___Poor social interactions
___Gets upset by changes in routine
___Often irritable
___Changes in appetite
___Diminished interest
___Sleep problems
___Restlessness or slowed down
___Fatigues, low energy
___Feels worthless
___Becomes tearful easily
___Often sad
___Indecisive/can't think
___Thinks about death
___Talks about suicide
___Hurts self
___Currently uses drugs
___Currently drinks beer or alcohol
___Used beer or alcohol in the past
___Can't stop thinking about things
___Excessive preoccupation with objects or ideas

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Please place a check mark in the column which best describes the child:	Not at all	Just a little	Pretty much	Very much
Often fails to give close attention to details or makes careless mistakes in schoolwork or other activities				
Often has difficulty sustaining attention in tasks or play activities				
Often does not seem to listen when spoken to directly				
Often does not follow through on special instructions and fails to finish schoolwork, or chores (not due to oppositional behavioral failure to understand directions)				
Often has difficulty organizing tasks and activities				
Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)				
Often loses things necessary for tasks or activities (toys, school assignments, pencils or books)				
Is often easily distracted by extraneous stimuli				
Is often forgetful in daily activities				
Often fidgets with hands or feet or squirms in seat				
Often leaves seat in classroom or in other situation in which remaining seated is expected				
Often runs about or climbs excessively in situation where it is inappropriate (in adolescents, may be limited to subjective feelings or restlessness)				
Often has difficulty playing or engaging in leisure activities quietly				
Is often “on the go” or often acts as if “driven by a motor”				
Often talks excessively				
Often blurts out answers before questions have been completed				
Often has difficulty waiting turn				
Often interrupts or intrudes on others (butts into conversation or games)				

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REASON FOR ASSESSMENT

Please describe in your own words what concerns you have about this child. Also, please add any additional information that you feel is important and may be helpful in our assessment.

What specific **question** do you have that you hope an evaluation will answer?

Your name_____ Relationship to child_____

Date: _____/_____/_____

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