CHILD'S HISTORY In order for our professionals to serve you better, please answer the following questions and return this form prior to your appointment, or you may bring it in with you. Feel free to add any extra comments on a separate sheet. If there are any questions you cannot, or choose not to answer, please leave them blank.

Today's date____________________Name of child______________________________________

Birthdate______________School____________________Grade________Teacher______________

Your name and relationship to child____

Name of child's legal guardian(s)____

Who referred you to Child Development Associates?_________________________________

CONCERNS

What are the main concerns you have about your child?_____________________________

____

____

____

A. How long has this problem been a concern?______________________________________

B. When did you first notice the problem?____

C. Who else have you seen for this problem?____

D. What evaluations have already been performed?___________________________________

____

E. What has already been done to treat this problem (diet, medications, counseling)? ____________

____

F. What have you done, personally, to address the problem? _______________________

____

G. What seems to help the most?____

PREGNANCY AND BIRTH

1. Was the pregnancy a) planned? Yes_____No_____
   b) welcomed? Yes_____No_____
   c) stressful? Yes_____No_____
2. How many weeks into the pregnancy was it diagnosed?___________________________
3. For the three months prior to the pregnancy and the first two months of pregnancy did the mother use any:
   prescribed medications? Yes_____No_____How much____________________
   recreational drugs? Yes_____No_____How much____________________
   alcohol? Yes_____No_____How much____________________
   tobacco? Yes_____No_____How much____________________
4. During the following seven months of pregnancy did the mother use any:
   prescribed medication? Yes_____No_____How much____________________
   recreational drugs? Yes_____No_____How much____________________
   alcohol? Yes_____No_____How much____________________
   tobacco? Yes_____No_____How much____________________
5. Where there any medical concerns or other issues during this pregnancy regarding mother and/or baby?____

____

____

____

6. What hospital was the child born in?______________________________
Address______________________________
7. Please list types of pain medications/anesthesia used during delivery______________
8. At the time of birth:
How long did the pregnancy last?__________weeks
How long was the labor?__________hours
What as the baby's birth weight?_____lbs____oz, length?________inches
head circumference?__________inches
Was the baby born vaginally_____or casesarean____?
Was the baby born head first_____breech____or other (explain)______________
Did the baby have? (please circle all that apply):

trouble breathing	yellow jaundice	blood transfusion
resuscitation	jitteriness	physical injuries
twin	seizures/fits	trouble sucking
birth defects	cord around neck	intensive care
fevers or low temperature		

9. Was the baby breast fed?_____How long?____________Bottle fed?_____Formula name__________
10. Did the baby have any early feeding problem?_____Describe______________________
____
11. Were there any other concerns or problems noted by either the doctors or parents? Please describe.
____
12. Is your child adopted?_____Does he/she know?____If not, do you intend to tell him/her?_____
At what age was the child placed in your home?______At what age was the child adopted?_____

HEALTH

1. Has your child had any of the following? (please circle all that apply):

measles	mumps	chicken pox	whooping cough
pneumonia	encephalitis	meningitis	ear infections
lead poisoning	allergies	vision problems	hearing problems
unexplained high fevers			

Please explain any you circled______________________________
____
2. Does your child have any of the following? (please circle any that apply):
A. sleep problems (falling asleep, staying asleep, nightmares, sleepwalking, etc.)
B. brain disorders (headaches, seizures, motor or vocal tics, tremors, confusion, muscle weakness, coordination difficulties, head injury, staring spells, unexplained anger or sudden and unprovoked emotional outbursts, etc.)
C. lung problems (shortness of breath, asthma, coughing, etc.)
D. skin disorders (acne, hair loss, birthmarks, dermatitis, eczema, etc.)
E. blood disorders (anemia, bleeding bruising, etc.)
F. heart problems (chest pain, surgery, congenital heart disease, murmur, etc.)
G. sexual problems (birth control, promiscuity, excessive masturbation, etc.)
H. kidney problems (bedwetting, infections, etc.)
I. muscle or bone problems (scoliosis, injuries, strains, spasticity, etc.)
J. history of poisoning (lead, chemicals, others)
K. gland problems (obesity, slow or fast growth, early or delayed puberty, thyroid problems, etc.)
L. stomach or bowel problems (diarrhea, vomiting, constipation, stomach aches, stool soiling, etc)
M. genetic disorders (birth defects, inherited traits, chromosome abnormalities

Please explain any of the items which you circled______________________________
____
____
____

3. Has your child ever been hospitalized? If so, explain each hospitalization, including ages, reasons, and length of stay:____________________

____

____

____

4. Has your child ever taken medication to help with behavior or emotional problems?

Age	Medicine	Doctor	Reason	When/Why stopped?

5. Does your child take ANY medication on a regular basis for chronic or recurring conditions? (Due to drug interactions, please list all medications.)

Medicine	Doctor	Reason	Start date

6. Has your child had any special diagnostic tests (x-rays, EEG, MRI, CT scan, blood tests, etc.)

Age	Test	Reason	Results

7. Have you ever suspected that this child might have been physically or sexually abused? Yes____ No____
If yes, please explain:____________________

____

____

DEVELOPMENT

1. Early development

A. At about what age did your child first:

	Age	Not sure of age, but: Early	On Time	Late
Smile, goo and coo?	____	____	____	____
Sit up?	____	____	____	____
Crawl?	____	____	____	____
Stand alone?	____	____	____	____
Speak real words?	____	____	____	____
Walk by self?	____	____	____	____
Feed self?	____	____	____	____
Use two word sentences?	____	____	____	____
Dress self (except buttoning and tying)?	____	____	____	____
Speak so that strangers understood?	____	____	____	____
Ride a tricycle?	____	____	____	____
Ride a bicycle?	____	____	____	____
Tie own shoe?	____	____	____	____

B. Do you have any concerns about your child's motor or muscle development?____________________

____

C. Do any of the following concern you regarding your child's language development? Please circle

trouble finding the right word	too few words
unconnected thoughts	repeats words/phrases over and over
has seen a speech therapist	speech clarity
following directions	seems confused when spoken to
stuttering	missing sounds (like **r** or **k**)

D. Have you ever been concerned or been told that your child's development (speech and language, coordination, growth or social abilities) was behind his/her peers?____________

E. Did your child seem to learn pre-academic skills such as numbers, colors, shapes, etc., at the same time as other children his/her age? If not, please explain:____________

SCHOOL

1. What is your impression of your child's learning potential? Please circle:
   low average above average gifted
2. Do you feel that your child is performing up to his/her potential in school? Yes____ No____
3. Do you feel that your child has any difficulties with (circle any that apply and explain):
   - reading____
   - writing____
   - arithmetic____
   - social studies____
   - science____
   - languages____
4. Is homework a problem? If so, please circle all that apply:
   - can't get started
   - forgets to bring home materials
   - doesn't understand the work
   - distracted by radio, TV or anything
   - battles or argues about doing work
   - needs you there constantly
   - no place to work
   - forgets assignments
   - doesn't anticipate deadlines
   - takes too long
   - the most stressful time of day
   - doesn't care/no motivation
5. Is your child's work made more difficult by problems with:

	Not at all	Somewhat	A lot
poor concentration	____	____	____
giving up too easily	____	____	____
inconsistent performance	____	____	____
poor motivation	____	____	____
disorganization	____	____	____
spacing out or daydreaming	____	____	____
not finishing things	____	____	____
having low frustration tolerance	____	____	____
anxiety/sadness	____	____	____
poor handwriting	____	____	____
rapidly shifting from one thing to another	____	____	____
being easily distracted	____	____	____
impulsiveness	____	____	____
anxious	____	____	____

6. Has your child ever been retained____ suspended____ expelled____ advanced a grade____?

SOCIAL

Does your child get along well with others? In what areas do you notice difficulties? Please answer **yes**, **no** or **sometimes** to the following. You may add comments.

- makes friends easily____
- has a best friend____
- plays well with others____
- shares easily____
- follows rules____

enjoys team sports________________
leads other children________________
helps others________________
easily influenced________________
prefers to be alone________________
is a party animal________________
bullies others________________
fights others________________
insists on having his own way________________

SELF-ESTEEM

Does your child (please circle):

have an "I can do it" attitude?	Yes	No	give up easily?	Yes	No
recover from upsets?	Yes	No	stand up for self?	Yes	No
recognize strengths?	Yes	No	lack confidence?	Yes	No
			act adventuresome?	Yes	No

FAMILY

1. Are you satisfied with how your family works? Please circle any that might apply:
   - lack of structure; rules
   - poor communication
   - poor division of chores, responsibilities
   - marital problems
   - no family "together times"
   - financial troubles
   - lack of "breathing space"
   - resentment of another member

   Comments:________________
2. Where and how does this child fit in the family? Please circle any that apply:
   - sibling rivalry (more than expected)
   - spoiled, always gets own way
   - a rescuer, can't stand upsets
   - a team player
   - a manipulator
   - a helper

   Born baby #__________out of __________children.
3. What types of discipline are used in your family? Use **M** to indicate which ones mother uses, **F** to indicate which ones father uses:
   - discussion and education__________
   - encouraging independent thinking__________
   - contracts/token systems__________
   - lecturing, nagging, yelling__________
   - positive reward and praise__________
   - time out__________
   - spanking__________
   - restriction/grounding__________

   For what is your child most frequently disciplined?________________

   What type of discipline(s) work best with your child?________________
4. Please circle any of the following stressors which might apply to your family's situation, or to which the child had an extremely strong reaction. Please note how long ago the stressor occurred:
   - Parental separation/divorce
   - death of a family member/important friend
   - change in school
   - financial stress
   - severe illness
   - move to a new house
   - change of job
   - pregnancy/birth of new child

   Comments________________
5. Are there any "family secrets" or important things we have left out? Please include such things as relationships between divorced parents, involvement of extended family, parental adjustment difficulties, etc.:________________

____

____

6. Please circle current marital status: married single divorced widowed live together
7. If divorced from biological parent, what are the custody arrangements (legal <u>and</u> physical, please)?

____

____

____

8. If divorced, what is the non-custodial parent's involvement with this evaluation?________________

____

9. What are the names and ages and relationship of other children living at the home?______________

____

10. Is there any family history of medical, developmental, learning, psychiatric, or legal difficulties? Yes_____ No_____ If yes, please list the individual's relationship to the child, the nature of each difficulty, and any treatments received. Please include past generations and extended family if you have such information:____

____

____

____

____

11. Please describe any psychiatric or psychological treatment this child or any sibling has received:

____

____

____

____

12. Please review each of the following lists of characteristics and check any item that applies to your child:

A. Does your child have any of the following attention related troubles?

_____fidgets
_____easily distracted
_____difficulty playing quietly
_____shifts from one activity to another
_____often interrupts or intrudes on others
_____often engages in physically dangerous activities
_____often blurts out answers to questions before completed
_____difficulty remaining seated
_____difficulty awaiting turn
_____difficulty sustaining attention
_____often does not listen
_____often loses things
_____difficulty following instructions
_____often talks excessively

B. Does your child have any of the following oppositional troubles?

_____often deliberately acts to annoy others
_____is often touchy or annoyed by others
_____often swears/uses obscene language
_____often blames others for own mistakes
_____often actively defies or refuses adult requests of rules
_____often takes or touches others' property without asking
_____often agues with adults
_____is often angry or resentful
_____is often spiteful or vindictive
_____often loses temper

C. Has your child had problems with any of the following?

_____stolen without confrontation
_____deliberate firesetting
_____breaking and entering
_____cruel to animals
_____forced someone else into sexual activity
_____often initiates physical fights
_____lies often
_____often truant from school
_____destroyed others' property
_____used a weapon in a fight
_____stolen with confrontation
_____physically cruel to people

D. Does your child show any of the following anxiety symptoms?

_____unrealistic worry about future events
_____persistent refusal to go to school
_____bothersome thoughts
_____unrealistic concerns about competence
_____repeated nightmares about separation from you
_____excessive distress when separated from home or from you
_____excessive need for reassurance
_____unrealistic and persistent worry that something will happen to you
_____avoidance of being alone
_____physical aches and pains
_____marked self consciousness
_____marked inability to relax
_____ongoing refusal to sleep alone

E. Does your child show:

_____diminished pleasure in activities
_____depressed or irritable mood most of the day, nearly every day
_____poor appetite or overeating
_____trouble sleeping or sleeping too much
_____feelings of worthlessness or excessive inappropriate guilt
_____poor concentration or difficulty making decisions
_____suicidal thoughts or actions
_____agitation or sluggishness
_____low self esteem
_____low energy or fatigue
_____feelings of hopelessness

F. Does your child have any of the following?

_____repeated unusual movements
_____complusive rituals
_____vocal tics
_____excessive reaction to noise or failing to react to loud noises
_____odd postures
_____motor tics
_____overreacts to touch

G. Has your child exhibited any symptoms of thought disturbance, including any of the following?

_____can't get to the point, loses train of thought
_____bizarre ideas (odd fascinations, strange ideas, hallucinations)
_____disoriented, confused, staring or "spacey"
_____incoherent speech (mumbles, uses words only the child understands)

H. Has your child exhibited symptoms of affective mood disturbance, including any of these?

_____explosive temper with little provocation
_____excessively monotonous or bland affect
_____situationally inappropriate emotions
_____excessive reaction to changes in routine
_____unusual fears
_____panic attacks
_____excessive mood swings

Comments regarding any of the above items which you checked:_______________________________
____
____
____

STRENGTHS

Please tell us about your child's most outstanding characteristics, hobbies, achievements, abilities, etc.:
____
____
____

Thank you for taking the time to complete this questionnaire. We know it is long and time consuming, but it really helps us to serve you and your child better. If you can return it to us prior to your visit, we will review what you have shared with us in order to better focus on your concerns. This information, as all Child Development Associates records, is strictly confidential. It will not be released to anyone without your written permission.