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Patient Name (Last, First, Middle) Date of Birth

Developmental History (circle)

Was the baby: Full term Premature Late? How early/late _____

Planned or Unplanned

Fetal Activity during pregnancy: _____

Pregnancy Complications (Circle as appropriate)

Early threatened miscarriage (y/n)

Toxemia (for example: high blood pressure, excessive weight gain, abnormal urine) (y/n)

Diabetes with or without complications (y/n)

Maternal drinking or drug use during pregnancy (y/n)

German measles (y/n)

Rubella (measles) (y/n)

Other viral illnesses (y/n)

Malnutrition (y/n)

Anemia (y/n)

Other infections (y/n)

Medications (y/n)

Special diets or eating habits during pregnancy (y/n)

Any complications with pregnancy (y/n)

Previous pregnancies (y/n)

Previous miscarriages or still births (y/n)

(If so, how many and when) _____

Labor:

Length of Labor_____ Induced? (y/n) _____

Medications administered during labor (pain medications, narcotics, analgesics)

_____

Delivery:

Vaginal or cesarean

Mother's health during delivery _____

Birth Weight _____pounds _____ounces

Apgar Scores (if you recall) _____

Infancy:

Breast or bottle fed

Age when weaned

What sort of baby was your child?

_____

_____

How responsive was your child to his/her mother?

_____

_____

Much crying (y/n) Colic Attacks? (y/n)

Developmental Milestones: (age in years/months)
First sat unsupported on a flat surface _____
First stood alone _____
First 3 or 4 steps without holding on _____
First 3 or 4 words with meaning, other than mama, dada _____
First 3 or 4 words to form first sentence _____
Was your child considered slow, average, or fast in comparison to siblings, other children?
_____
Age when control training was begun_____
Age when occasional accidents no longer occurred_____
Difficulties in bowel/.bladder training_____
Have other members of the family had difficulty with bedwetting/soiling? _____
If so, who _____

Health History: This section concerns general health

State of general health: _____
Missed school because of illness? (y/n)_____
Health problems within the past year? (y/n)_____
Breathing difficulties (asthma)? (y/n)_____
Headaches (y/n) If yes, when, how often, affect sight, time of day, what makes better or worse?
_____
_____
Stomachaches (y/n) _____
Excessive vomiting, belching (y/n) _____
Eating problems—home or school (y/n) _____
Sleeping difficulties (y/n) _____
Sleepwalking (y/n) _____
Nightmares or night terrors (y/n)—which one? _____

Enuresis (bedwetting or daytime accidents) (y/n) _____
Wetting away from home (y/n) _____
Painful urination, dribbling, blood in urine(y/n) _____
Encopresis (soiling accidents) (y/n) _____
Smearing (y/n) _____

Muscular system and concentration
Activity range (overactive, normal, underactive) _____
Stay still if expected to (y/n) How long? Doing what? _____
Preferred hand/foot (right/left) _____
Coordination (very coordinated, average, clumsy)_____

Speech and language
Understands spoken language well (y/n) _____
Expresses his/her ideas well (y/n) _____
Has difficulty pronouncing words (y/n) _____
Lisps (y/n) _____
Baby talk(y/n) _____
Stutter_____
Family history of a speech problem_____

Tic and habitual mannerisms:

Twitches face and/or shoulders (y/n) _____
Blinking(y/n) _____
Lip smacking(y/n) _____
Other tics(y/n) _____
Thumb-sucks(y/n) _____
Nail biting(y/n) _____
Head banging(y/n) _____
Sucks tongue(y/n) _____
Favorite soft toy or blanket(y/n) _____

Episodic Disorders:

Fainting spells(y/n) _____
Convulsions(y/n) _____
Petit Mal seizures(y/n) _____
Blinking, staring, or absence attacks(y/n) _____
Grand mal seizures(y/n) _____

Allergies: _____
Name and Address of Pediatrician: _____
_____
_____
Phone number of primary care provider: _____
Any serious illnesses/injuries(y/n) _____
Meningitis, encephalitis, head injury, skull fracture, concussion, periods of unconsciousness, coma (y/n) (circle) when? _____
Hospitalized ever? (y/n)
_____
Emergency Room visits (y/n) Why?
_____

Medications: (name/dose/for what illness)

Current:_____
_____
_____
_____
Past_____
_____
_____
_____

Sexual Development
Is child interested in the opposite sex? (y/n) _____
Does child show interest in sex? (y/n) _____
Is the child taught about sex by parents? (y/n) _____
Does child ask questions about sex? (y/n)_____
Does child have problems related to sex? (y/n) _____
Has child had any disturbing sexual experiences? (y/n) _____

Child's Personality: Emotions and Moods (Please circle)
Generally speaking, my child (is):
Happy or sad
Full or worries or is secure
Cries easily or holds it in
Fussy (y/n)
Has many rituals and/or compulsions
Irritable or complacent
Easygoing or nervous
Going to school easily or refuses
Stubborn or submissive

Peer Relationships: (Please elaborate if the answer is yes.)
How does child get along with other children?

_____
_____
Makes friends easily? (y/n)_____
Has many friends? (y/n) _____
Plays with friends outside of school? (y/n)_____
_____
Prefers children of own age, younger, older?
_____
_____
Prefers same gender playmate or opposite gender? _____
_____
Is a leader or a follower? _____
Bully or bullied? _____
Member of club? _____
Member of gang? _____

Relationship with brother(s) and/or sister(s):

List names/ages/any behavioral or educational problems:
_____
_____
_____
_____

How does the child get along with each? (Closest to whom? Worst with? Jealous of?)
_____
_____
_____
_____

Relationship with parents and adults:

Does your child seek out parents for love and affection? _____
_____
_____
_____
Do you think your child loves you? _____
How does your child show affection to parents? _____
_____
Is your child easy to get along with? _____
What do you like about your child? _____
_____
What does your child do that annoys you? _____
_____
How do you show love and affection to your child? _____
_____
_____

What activities do you do with your child?
(Please identify mother/father/stepparent/caregiver/ etc.)

Play: Adult 1:_____
Adult 2: _____
Adult 3: _____

Homework: Adult 1: _____
Adult 2: _____
Adult 3: _____

Make things: Adult 1: _____
Adult 2: _____
Adult 3: _____

How much time is spent with the child: Adult 1: _____
Adult 2: _____
Adult 3: _____

How does your child get along with adults? _____
_____

How does your child get along with teachers? _____
_____
Is child attached to any other adults? (y/n) If so, to whom? _____
_____
Does anyone help look after him/her? _____
_____
How often? _____
Relationship and behavior with sitters? _____
_____

Social Behavior and Integrity:

Aggressiveness? (y/n) _____
Disobedience? (y/n) _____
Lying? (y/n) _____
Fire setting? (y/n) When? _____
_____
Stealing? (y/n) When? _____
_____
In trouble with the law? (y/n)_____
Running away? (y/n) _____
Smoking, drinking, using marijuana or other drugs? (y/n) _____
_____
_____

Parents' rules and attitudes toward discipline:
Bedtime rules: _____
Dress/grooming codes: _____
Is child helped with dressing? (y/n) Who helps? _____
_____
May child leave the house and travel alone? (y/n) How far? _____
_____
Restrictions on friends? _____
For what is child punished? _____
Under what conditions is child spanked, hit, or beaten? _____
_____
_____
Who usually punishes the child? _____
What punishment is effective? _____
_____
Does child repeat the same offense? _____
_____
_____

Individual Responsibility:
How much allowance does child get? _____
What does child have to do for it? _____
Can child lose allowance? _____
What does child do with his/her money? _____
What are child's household chores? _____
What is child encouraged to do on own? _____
_____
What is child discouraged from doing on own? _____
_____

This section will be concerned with information about the child's family, parents, and the parents' families of origin. Questions should be answered for both parents where appropriate. (If needed, more space can be found on the back of this page)

Date when parents married _____ Divorced _____

How did parents first meet? _____

_____

_____

Religion: Parent 1: _____

Parent 2: _____

Occupation: Parent 1: _____

Parent 2: _____

Education level: Parent 1: _____

Parent 2: _____

Parental Relationship:

How get along? _____

Enjoy doing things together? (y/n) Examples: _____

_____

Parents married before/again? (y/n) When? Parent 1: _____

Parent 2: _____

Children from previous marriage? (y/n) List names and ages _____

_____

_____

_____

Children from new marriage? (y/n) List names and ages _____

_____

_____

_____

Adopted or foster children? (y/n) List name and ages_____

_____

_____

Overall health: Parent 1: _____

Parent 2: _____

How do you spend evenings and weekends? _____

_____

_____

Who participates in household chores? _____

What arrangements are made for 'free time'? _____

_____

Parent 1's History:
Name: _____ Date of Birth _____
Where were you born and raised? _____
Parents: living or deceased? _____
Where do your parents live? _____
Are they in good health? _____
Describe your relationship with parents? _____
How much contact do you have with your parents? _____
Remembrance of childhood: _____
Parent 1's brother(s) and sister(s) (Names and ages)
_____
_____
_____
What was your position in the family? _____
Your economic surrounding at present? _____

Parent 2's History:
Name: _____ Date of Birth _____
Where were you born and raised? _____
Parents: living or deceased? _____
Where do your parents live? _____
Are they in good health? _____
Describe your relationship with parents? _____
How much contact do you have with your parents? _____
_____
Your remembrance of childhood: _____

Parent 2's brother(s) and sister(s) (Names and ages)
_____
_____
_____
What was your position in the family? _____
Your economic surrounding at present? _____

Family History:
Is there anyone in the immediate or extended family: (Circle and identify family member, e.g. grandparent, mother, sister, aunt, etc. and which side of the family.)

With mental disorder (y/n) _____
Who received psychiatric treatment (y/n) _____
Taking tranquilizers (y/n) _____
Taking sleeping pills (y/n) _____
With sleeping problems (y/n) _____
Who has been hospitalized for emotional problems (y/n)
_____
Who has ever tried to kill themselves (y/n) _____
Who has ever committed suicide (y/n) _____
With a drinking problem (y/n) _____
With arrests for drunken driving (y/n) _____
With drug abuse problems (y/n) _____
With difficulty with the law (y/n) _____
Who has served time in jail (y/n) _____
With gambling issues (y/n) _____

With depression (y/n) _____
With cycles of happiness (elation) and sadness (y/n)
_____
With fatal disease (y/n) _____
With anxiety (y/n) _____
With learning issues (y/n) _____
Who has been diagnosed as on the autistic spectrum (y/n)
_____

School History:
These sections will be concerned with your child's school experience and educational history.
Did child attend pre-school? (y/n) Where? _____
Which school does your child attend now? _____
Teacher's name: _____
Present grade and/or special class assignment: _____
General class size: _____
Type of educational setting (i.e. self-contained, combined grade, open classroom, etc., if known):
_____
Special supportive services (i.e. speech, tutoring, resource room, counseling, etc.)
_____
How often? _____
Does childlike school? (y/n) _____
Is child making satisfactory progress? (y/n) _____
Grades repeated? _____
Have you seen your child's teacher? (y/n) Why? _____

Formal Evaluations:
Has your child ever had formal educational/psychological testing? (y/n)
Dates, if known: _____
Where was this done? (i.e. name of school, clinic, provider, etc.)
_____

Vision:
Has difficulty seeing ever been suspected? (y/n) _____
Have glasses been prescribed? (y/n) _____
Does your child wear them in school? _____

Hearing:
Has hearing difficulty ever been suspected? (y/n) _____
Has your child had a hearing test? (y/n) If yes, date and results: _____
_____
Where was this done? _____

Handwriting:
Which method of writing does your child use? Printing or cursive
Is the quality of writing satisfactory for age? (y/n) _____
Which hand is used? Right or Left

Are there any noticeable problem areas in regards to written work? (y/n) If yes, please comment:
_____
_____

Does your child enjoy reading? (y/n) _____
Is this a problem area in school? (y/n) _____
Is this done at home for pleasure? (y/n) _____
Are there specific subject areas in which your child is experiencing difficulties? (y/n) If yes, please list and/or comment: _____
_____
_____
Is your child assigned homework? (y/n) _____
Is this a source of problems: (y/n)
_____?
What is the quality of completed assignments? _____
_____
Is it necessary to repeat directions? _____
Does your child have difficulty remembering information? (y/n) _____
_____

School Behavior:
Which of the following describes your child in school? Please circle and or comment.

Hyperactive (very active) (y/n) _____
Limited attention span (y/n) _____
Limited concentration (y/n) _____
Easily distractible (y/n) _____
Disorganized (y/n) _____
Destructive (y/n) _____
Dependent (y/n) _____
Easily frustrated (y/n) _____
Overly talkative (y/n) _____
Lacks self-confidence (y/n) _____

How are school reports and recent grades? (Recent grades from report cards.)
_____
_____
Have your child's grades improved or become worse over the last school year?
_____
_____
If there are school problems, when did they start? _____
_____
_____
_____
What do you view as the reason for these problems? _____
_____
_____
_____
What school-related questions would you like to see answered? _____
_____
_____
_____
What else would you like me to know that has not been asked? _____
_____
_____
_____

What questions do you have for me? What do you hope this evaluation will accomplish?