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

Significant Childhood History

Pregnancy and Delivery:

_____
_____
_____
_____
_____
_____

Infancy and Toddlerhood:

_____
_____
_____
_____
_____
_____

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 _____

School History:

Highest level of education and if attended professional program/higher education program where and when did you graduate with what degree:

_____
_____
_____

Current occupation (part time/fulltime):

_____

Did you have any difficulty during school? (Y / N) If so, please elaborate.

_____
_____
_____

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) _____

Health History: This section concerns general health

State of general health: _____
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) _____
Painful urination, dribbling, blood in urine(y/n) _____
Encopresis (soiling accidents) (y/n) _____
Smearing (y/n) _____
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)_____

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 Primary care provider:
_____
_____
_____
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_____
_____
_____
_____

Personality: Emotions and Moods (Please circle)
Generally speaking, my child (is):
Happy or sad
Full of worries or secure
Cries easily or holds it in
Many rituals and/or compulsions
Irritable or complacent
Easygoing or nervous
Stubborn or submissive

Peer Relationships:
How do you get along with others?
_____
_____
Do you make friends easily? (y/n)_____
Have many friends? (y/n) _____

Relationship with siblings:

List names/ages/any health/behavioral/or educational issues: Also, whether or not you get along with them.
_____
_____
_____
_____

Relationships:

Please describe your relationship with your parents. How often do you see/communicate with them? _____
_____
_____
_____

Do you have a significant other? _____
How long have you been together? _____
_____
How would you describe your relationship?
_____
What do you do with your significant other?
_____

Do you have children? (Y / N)
Names and ages/grades (if applicable):
_____
_____
_____

Do your children present any challenges for you:
_____
_____
_____

Who participates in household chores? _____
What arrangements are made for 'free time'? _____
_____

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)
_____

Formal Evaluations:
Has you 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) _____

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

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?
_____
_____
_____
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