CHILD or ADOLESCENT CLIENT HISTORY

CLIENT:
Legal Name_____ Date of Birth _____ Age____
Address: _____City: _____ State: _____ Zip: _____
Phone: Home _____ Mom cell _____ Dad cell _____

_____ _____ _____
Name of person completing form Relationship to client Today's date

Referred by:_____ **Client's Doctor:**_____

PARENTS:
With whom does the child primarily reside? Circle all that apply.
Biological Mother Adoptive Mother Step-Mother Grandmother Foster Mother
Biological Father Adoptive Father Step-Father Grandfather Foster Father
Other: _____ (Name/Relationship)
If parents are separated, who has **legal** custody? _____
Who else has visitation? _____
Date of separation: _____ Date of divorce: _____
If child is adopted, place of birth: _____ Age at adoption:_____

BIRTH MOTHER:_____ DOB _____
Place of Employment _____ Position _____Phone _____

BIRTH FATHER:_____ DOB _____
Place of Employment _____ Position _____Phone _____

ADOPTIVE PARENT: _____ DOB _____
Place of Employment _____ Position _____Phone _____
Highest Level completed in school _____

ADOPTIVE PARENT: _____ DOB _____
Place of Employment _____ Position _____Phone _____
Highest Level completed in school _____

STEP-PARENT or **OTHER RELATIVE:**
Name _____ DOB _____
Place of Employment _____ Position _____Phone _____
Highest Level completed in school _____

SIBLINGS: (please specify whether full-, step- and/or half-siblings)
Name Age Sex Living in Home? Any School or Behavior Problems?
_____
_____
_____
_____
_____

Does anyone else live in the home besides the people listed above? Yes No

What are your primary concerns about your child?

Has your child been diagnosed with (or have you ever questioned) any of the following conditions? If so, please describe the condition and type of treatment:

Autism, P.D.D., or Asperger's
learning disorders
attention problems
hyperactivity or impulsivity
asthma
lead or other poisoning
seizures or epilepsy
hydrocephalus
cerebral palsy
hypotonia (low muscle tone)
muscle problems
intellectual disabilities/mental retardation
developmental delay
heart problem
depression or anxiety
vision or hearing problems
genetic disorders
Any other serious medical or mental health disorder?

What medications has your child taken for the above conditions?

Name of medication	Dose	For what?	Past or now?	How long?	Response

What other treatment has your child received (not including surgeries) currently and in the past?

	Clinician	How often	Starting when	Past/now?
speech and language therapy				
occupational therapy				
physical therapy				
counseling/therapy				
tutoring				
other				

FAMILY HISTORY

BIRTH MOTHER: _____Age_____Occupation_____

Country of Origin _____ Languages _____

Highest Level Completed In School_____Diploma/Degree?_____

Has the child's mother or anyone in the mother's family ever experienced, now or in the past, any of the following, even if it was not formally diagnosed?

In the blank on the left, write to WHOM it applies, indicating the person's relationship to the **child** (e.g., mother, grandmother, uncle, cousin, etc.).

_____ special education classes or tutoring? Describe: _____
_____ repeat any grades or fail any subjects? Describe: _____
_____ difficulty in reading, spelling, writing, math? (please circle which one or ones)
_____ behavior problems? Describe:_____
_____ attention problems or ADD
_____ hyperactivity, impulsivity, or ADHD
_____ delays in development, such as motor, language, or cognitive (please circle)
_____ anxiety
_____ depression
_____ seizures
_____ alcohol or substance abuse
_____ unusual medical problems? Describe: _____
_____ other, describe:_____

BIRTH FATHER: _____Age_____Occupation_____

Country of Origin _____ Languages _____

Highest Level Completed In School_____Diploma/Degree?_____

Has the child's father or anyone in the father's family ever experienced, now or in the past, any of the following, even if it was not formally diagnosed? In the blank on the left, write WHO, indicating the person's relationship to the **child** (e.g., mother, grandmother, uncle, cousin, etc.).

_____ special education classes or tutoring? Describe: _____
_____ repeat any grades or fail any subjects? Describe: _____
_____ difficulty in reading, spelling, writing, math? (please circle which one or ones)
_____ behavior problems? Describe:_____
_____ attention problems or ADD
_____ hyperactivity, impulsivity, or ADHD
_____ delays in development, such as motor, language, or cognitive (please circle)
_____ anxiety
_____ depression
_____ seizures
_____ alcohol or substance abuse
_____ unusual medical problems? Describe: _____
_____ other, describe:_____

MEDICAL HISTORY

PREGNANCY: Length in weeks:_____ Premature?_____
Any illnesses or complications while pregnant? Describe: _____

_____

_____

Did the mother use any cigarettes, alcohol or other substances before/during pregnancy? Please specify: _____

How many pregnancies and/or miscarriages has mother had? Please explain:_____

_____

LABOR AND DELIVERY:
Type of Labor? _____Spontaneous _____Induced If labor was induced, please explain why:

_____

Type of delivery? _____Vaginal _____Caesarean (C-section), describe reason:

_____

Any special circumstances? _____forceps ____vacuum assist _____multiple birth
Complications during labor or delivery (e.g., breech, cord around neck, heart rate problems), describe:_____

_____

Anesthesia? _____ Other: _____

PERINATAL HISTORY: Birth Weight_____Length_____Head Size_____
APGAR scores (if known):_____How long did baby stay in hospital?_____
Did mother or baby stay in Special or Intensive Care? If yes, please describe:_____

_____

_____

Any problems or concerns immediately after birth?

_____jaundice
_____blood transfusions
_____seizures/convulsions
_____problems breathing
_____baby given oxygen
_____incubator
_____problems sucking
_____body temperature problems
_____heart monitor
_____Other: _____

_____

Any birth defects?_____

INFANCY AND CHILDHOOD:
Please describe any hospitalizations, surgery, or ER visits for serious emergency since birth, including the condition, treatment, any surgery, when, and how long: _____

_____

_____

_____

Does your child suffer from **allergies**? Yes No
Please explain type of allergies and treatment being received:_____

_____

Number of **ear infections**: _____Birth-1yr. _____1-2yrs. _____2-3yrs. _____3yrs+

Date of **last hearing test**_____ By whom? _____ Normal? Yes No
Is a hearing aid, cochlear implant, or Personal FM Monitor used? If so, please describe:_____
_____

Date of **last vision test**_____ By whom? _____ Normal? Yes No
Are glasses or contact lenses worn? If so, why?_____
_____

Do you have concerns about your child's eating or sleeping? Please describe: _____
_____
_____

DEVELOPMENTAL AND BEHAVIORAL HISTORY

INFANCY:
Describe your child as a baby, up to about 18 months: _____
_____

Circle any of the following that apply to you child as a baby**:** colicky and irritable, feeding problems, sleeping problems, restless, did not enjoy cuddling, avoided eye contact, avoided social contact, or difficult to soothe.

List the approximate ages at which your child reached the following **developmental milestones**:
Language: used single words _____ used phrases _____
Gross Motor: crawled _____ walked alone _____
Fine Motor: fed self with spoon/fork _____ scribbled _____ tied shoes _____
Social/Adaptive: dressed self with help _____ potty trained – day _____ night _____

Overall, do you feel your child has **developed at a slow, normal or fast rate?** (circle one)

Childhood:
Which of the following describe your child since about 18 months of age:

sad	leader	happy	follower
moody	quiet	even tempered	over-active
friendly	independent	prefers to be alone	dependent
sensitive	trouble sleeping	hard to discipline	affectionate
fearful	too responsible	temper tantrums	cooperative

Please list any **very stressful, possibly traumatic, or unusual events** in your child's life that you feel may have had an impact upon his or her development and current functioning. Include the incident, child's age, and other comments:
_____
_____
_____
_____

SCHOOL / EDUCATIONAL HISTORY

If your child has attended school, please **circle** the current level below. Then, describe your child's performance and any concerns up to the current level:

Preschool (school attended:)

Kindergarten (school attended:)

1st Grade (school attended:)

2nd Grade (school attended:)

3rd Grade (school attended:)

4th Grade (school attended:)

5th Grade (school attended:)

6th Grade (school attended:)

7th Grade (school attended:)

8th Grade (school attended:)

9th Grade (school attended:)

10th Grade (school attended:)

11th Grade (school attended:)

12th Grade (school attended:)

College or Vocational training (school attended:)

Do any of the following apply to the child now or in the past?

_____ Special education placement _____ Resource room

_____ Repeated a grade/failed a subject _____ Tutoring

If so, explain: _____

In what grade were services started? _____ Currently receiving services? _____

Does or did the child have any accommodations and modifications? _____

Has your child had individual IQ and/or achievement testing? Yes No

If yes, by whom and when: _____

THANK YOU! IF THERE IS ANY OTHER INFORMATION YOU FEEL WE SHOULD HAVE, PLEASE CHECK HERE ☐ AND DESCRIBE ON THE BACK OF THIS PAGE.