

CHILD PSYCHOLOGICAL HISTORY

Child's Name _____ Date _____

Parent/guardian Tel: (home) _____ (work) _____

Age _____ Birthdate _____ Religion (optional) _____

Sex _____ Ethnic or racial background _____

Grade and school _____

Hand child uses for writing or drawing: Right Left Switches between them

Primary language _____ Secondary language _____

Previous diagnosis (1) _____

If any (2) _____

Who referred the child to our office? _____

Briefly describe the problem: _____

What specific concerns do you have?

(1) _____

(2) _____

(3) _____

THIS FORM HAS BEEN COMPLETED BY:

Name _____ Relationship to child _____

Address _____

Phone (H) _____ (W) _____

SYMPTOM SURVEY

For each symptom that applies to the child, place a check. Compare the child to other children of the same age. Add any helpful comments next to the item.

1) PROBLEM SOLVING

- Difficulty figuring out how to do new things
- Difficulty making decisions
- Difficulty planning ahead
- Difficulty solving problems a younger child can do
- Disorganized in his/her approach to problems
- Difficulty understanding explanations
- Difficulty doing things in the right order (sequencing)
- Difficulty verbally describing the steps involved in doing something
- Difficulty changing a plan or activity in a reasonable period of time
- Is slow to learn new things
- Difficulty switching from one activity to another activity
- Easily frustrated
- Other problem solving difficulties _____

2) SPEECH, LANGUAGE, AND MATH SKILLS

- Difficulty speaking clearly
- Difficulty finding the right word to say
- Not talking
- Rambles on and on without saying much
- Jumps from topic to topic
- Odd or unusual language or vocal sounds
- Difficulty understanding what others are saying
- Difficulty in writing letters or words
- Difficulty reading letters or words
- Difficulty with spelling
- Difficulty with math
- Other speech, language, or math problems: _____

3) SPATIAL SKILLS

- Confusion telling right from left
- Has difficulty with puzzles, Legos, blocks, or similar games
- Problems drawing or copying
- Doesn't know his/her colors
- Difficulty dressing (not due to physical difficulty)
- Problems finding his/her way around places he/she has been before
- Difficulty recognizing objects
- Seems unable to recognize facial or body expressions of disapproval or emotions
- Gets lost easily
- Other spatial problems: _____

4) AWARENESS AND CONCENTRATION

- Easily distracted by: Sounds Sights Physical sensations
- Mind appears to go blank at times
- Loses train of thought
- Difficulty concentrating on what others say, but can sit in front of a TV for long periods
- Attention starts out OK but can't keep it up
- Other attention or concentration problems: _____

5) MEMORY

- Forgets where he/she leaves things
- Forgets things that happened recently (e.g., last meal)
- Forgets things that happened days/weeks ago
- Forgets what he/she is supposed to be doing
- Forgets names more than most people do
- Forgets school assignments
- Forgets instructions
- Other memory problems: _____

6) MOTOR AND COORDINATION

Check the side this occurs on:

Right side Left side Both sides

- | | | | | |
|--------------------------|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | Poor fine motor skills (e.g., using a pencil or crayon) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | Clumsy) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | Weakness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | Tremor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | Muscles are tight or spastic | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | Odd movements (posturing, peculiar hand movements, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | Drops things more than most children | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | Has an unusual walk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | Balance problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | Other motor or coordination problems: _____ | | | |

7) SENSORY

Check the side this occurs on:

Right side Left side Both sides

- | | | | | |
|--------------------------|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | Needs to squint or move closer to page to read | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | Problems seeing objects | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | Loss of feeling | | | |
| <input type="checkbox"/> | Problems hearing sounds | | | |
| <input type="checkbox"/> | Difficulty telling hot from cold | | | |
| <input type="checkbox"/> | Difficulty smelling odors | | | |
| <input type="checkbox"/> | Difficulty tasting food | | | |
| <input type="checkbox"/> | Overly sensitive to: Touch <input type="checkbox"/> Light <input type="checkbox"/> Noise <input type="checkbox"/> | | | |
| <input type="checkbox"/> | Other sensory problems: _____ | | | |

8) PHYSICAL

How Often?

- | | | |
|--------------------------|---|-------|
| <input type="checkbox"/> | Frequently complains of headaches or nausea | _____ |
| <input type="checkbox"/> | Had dizzy spells | _____ |
| <input type="checkbox"/> | Has pains in joints Where? _____ | |
| <input type="checkbox"/> | Excessive tiredness | |
| <input type="checkbox"/> | Frequent urination or drinking | |
| <input type="checkbox"/> | Other physical problems: _____ | |

9) BEHAVIOR

- | | |
|---|--|
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Attached to things, not people | <input type="checkbox"/> Nightmares, night terrors, sleepwalks |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Quiet |
| <input type="checkbox"/> Bizarre behavior | <input type="checkbox"/> Resists change |
| <input type="checkbox"/> Bowel movement in underwear | <input type="checkbox"/> Risk-taking |
| <input type="checkbox"/> Dependent | <input type="checkbox"/> Self-mutilates |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Self-stimulates |
| <input type="checkbox"/> Eating habits are poor | <input type="checkbox"/> Shy and withdrawn |
| <input type="checkbox"/> Emotional | <input type="checkbox"/> Sleeping habits are poor |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Swears a lot |
| <input type="checkbox"/> Immature | <input type="checkbox"/> Unmotivated |
| <input type="checkbox"/> Other unusual behavior: _____ | |

Below check all the descriptions of the child that have been present for at least the **past 6 months**.

These behaviors should occur more frequently than in other children of the same age.

- | | |
|---|--|
| <input type="checkbox"/> Is very fidgety | <input type="checkbox"/> Steals things without people knowing on several occasions |
| <input type="checkbox"/> Can't remain seated | <input type="checkbox"/> Often runs away from his parents' home and stays away overnight |
| <input type="checkbox"/> Highly distractible | <input type="checkbox"/> Easily lies to others |
| <input type="checkbox"/> Can't wait for his/her turn when playing with others | <input type="checkbox"/> Firesetting |
| <input type="checkbox"/> Answers before he/she hears the whole question | <input type="checkbox"/> Doesn't go to school |
| <input type="checkbox"/> Rarely follows others' instructions | <input type="checkbox"/> Breaks into other people's property |

- | | |
|---|---|
| <input type="checkbox"/> Has a hard time concentrating for long periods | <input type="checkbox"/> Destroys other people's property in some manner other than by fire |
| <input type="checkbox"/> Goes from one activity to another without finishing anything | <input type="checkbox"/> Seems like he/she is always talking |
| <input type="checkbox"/> Frequently makes noise when playing | <input type="checkbox"/> Is cruel to animals |
| <input type="checkbox"/> Is often rude or interrupts others | <input type="checkbox"/> Has forcible sexual relations with others |
| <input type="checkbox"/> Doesn't listen to other people | <input type="checkbox"/> Starts fights with others |
| <input type="checkbox"/> Seems like he/she frequently is losing things that are needed for school | <input type="checkbox"/> Will steal directly from people |
| <input type="checkbox"/> When fighting, has used a weapon on more than one occasion | <input type="checkbox"/> Is cruel to other people |
| <input type="checkbox"/> Frequently does dangerous things without considering consequences | |

10) Overall, the child's symptoms have developed: Slowly Quickly

11) The symptoms occur: Occasionally Often

12) Over the past 6 months the symptoms have: Stayed about the same Worsened

PREGNANCY

13) Mother's age at child's birth: _____ Father's age at child's birth: _____

14) **Before** the pregnancy, what medications (prescribed or over-the-counter) did the mother take?

List all medications used: _____

15) While pregnant, what medications (prescribed or over-the-counter) did the mother take?

List all medications used: _____

16) How often did the mother see her doctor during the pregnancy?

Regularly (as scheduled by the doctor) Rarely Not at all

17) During the pregnancy, which of the following did the mother use?

| | Amount and Daily Frequency |
|---|----------------------------|
| <input type="checkbox"/> Alcohol | _____ |
| <input type="checkbox"/> Caffeine | _____ |
| <input type="checkbox"/> Marijuana | _____ |
| <input type="checkbox"/> Recreational drugs (cocaine, heroin, etc.) | _____ |
| <input type="checkbox"/> Tobacco | _____ |

18) During the pregnancy, the mother's diet was: Good Poor

If poor, explain: _____

19) The mother's general physical health during the pregnancy was: Good Poor

If poor, explain: _____

20) About how much weight did the mother gain while she was pregnant? _____ lbs.

21) During this pregnancy, check all the mother had:

- Accident
- Anemia
- Bleeding (severe or frequent spotting)
- Diabetes
- High blood pressure
- Preeclampsia, eclampsia, or toxemia
- Psychological problems
- Surgery
- Vomiting (severe or frequent)

22) How many pregnancies did the mother have prior to this one?

Number of live births: _____

Number of miscarriages: _____

BIRTH

23) Was this child born:

Early How early? _____ weeks

On time (38-42 weeks)

Late How late? _____ weeks

24) How much did the baby weigh at birth? _____ lbs. _____ oz or _____ gms.

25) How long did the labor last? _____

26) The labor was: Easy Moderately difficult Very difficult

27) What type of medication was the mother given to help with the delivery?

None Demerol Gas Regional nerve (spinal block) Tranquilizer Epidural

28) Were forceps used during delivery? Yes No

29) Was the baby born:

Head first Transverse(crosswise) Posterior first

Breech birth Caesarean section Vacuum extraction

Other: _____

30) Did the baby experience any of these problems:

Fetal distress Low placenta (Placenta previa) Prolapsed cord

Premature separation of placenta (Abrupto placenta) Cord wrapped around neck

31) Describe any other special problems the mother or child had during delivery:

32) At birth, did the baby:

Have difficulty breathing? Yes No

Fail to cry? Yes No

Appear inactive? Yes No

33) List the baby's Apgar scores: 1st _____ 2nd _____

34) If the father or the mother noticed anything unusual when they first saw the baby, describe:

If the baby was born with any problems (congenital defects, large or small head, blue baby, bleeding in brain, etc), describe: _____

Describe any special problems that the baby had in the first few days following birth:

Describe any special care, treatment, or equipment the child was given after birth:

How long did the baby stay in the hospital? _____

DEVELOPMENTAL HISTORY

35) For each area, indicate the child's development by circling one description. The "average" period is only a rough idea of what is average since every developmental milestone actually involves a range of several months (e.g. walking occurs approximately 9-18 months of age). Circle "early" or "late" only if you are sure the child's development was different from that of most other children.

GROSS MOTOR SKILLS

| | | | |
|---------|-------|-------------------|------|
| Crawled | Early | Average (6-9 mos) | Late |
|---------|-------|-------------------|------|

| | | | |
|--------------------------|-------|--------------------|------|
| Walked alone (2-3 steps) | Early | Average (9-18 mos) | Late |
|--------------------------|-------|--------------------|------|

LANGUAGE

| | | | |
|--------------------------|-------|---------------------|------|
| Followed simple commands | Early | Average (12-18 mos) | Late |
|--------------------------|-------|---------------------|------|

| | | | |
|----------------------------|-------|---------------------|------|
| Used single-word sentences | Early | Average (12-24 mos) | Late |
|----------------------------|-------|---------------------|------|

SELF-HELP

Toilet trained

Early

Average (13-36 mos)

Late

36) List any other significant developmental problems:

37) Overall, the child's development was:

Early

Average

Late

38) As an infant or toddler, did the child have poor muscle control (i.e. weakness) of the:

Neck

Trunk

Legs

Arms

39) As an infant or toddler, did the child's muscles seem to be unusually tight or stiff?

Yes

No

If yes, describe: _____

40) Toilet training was:

Easy

Difficult

41) As an infant or toddler, the child was:

Too calm and inactive

Calm and reasonably active

Irritable and very active

42) As a toddler, the child was:

Shy and inhibited

Neither shy nor outgoing

Very outgoing and liked people

43) Did the child have a poor appetite as a baby? Yes No

44) Did the child fail to gain weight steadily as a baby? Yes No

45) List the baby's illnesses or physical problems during the first year:

46) Has the child had a temperature of 104°F (40°C) or higher for more than a few hours?

Yes No If yes, what age (s)? _____ and how long did it last? _____

47) Has the child ever been hit hard on the head or suffered a head injury? Yes No

If yes, what age(s)? _____ Did the child lose consciousness? Yes No

How did it happen? _____

What problems did the child have (physical or mental) afterwards?

48) Has the child been diagnosed with seizures or epilepsy? Yes No

If yes, which type? Partial seizure Generalized seizure Unclassified type

If medication is used, which medication(s)? _____

Has the child ever had a bad reaction to this medication? Yes No

If yes, describe: _____

Did the child ever have a seizure due to a fever or unknown cause? Yes No

If yes, describe (age, nature of seizure): _____

49) Was the child ever in the hospital for an accident, injury or operation? Yes No

If yes, what age(s)? _____ What happened? _____

50) Has the child ever swallowed any poison, non-food, or drug accidentally? Yes No

If yes, what age(s)? _____ What happened? _____

51) Did the child have frequent ear infections?

Yes

No

If yes, what age(s)? _____ How often and severe? _____

What treatment was provided? _____

52) Please check all the following diseases or conditions the child has ever had:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Kidney disorder | <input type="checkbox"/> Oxygen deprivation |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Colds (excessive) | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disorder | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Lung disorder | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Brain disorder | <input type="checkbox"/> Enzyme deficiency | <input type="checkbox"/> Measles | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Genetic disorder | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disorder | <input type="checkbox"/> Metabolic disorder | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Other problems: _____ | | | |

53) As the child has been growing up, he/she has been sick:

Much of the time

An average amount

Not much at all

54) List all the medications the child takes now:

Medication

Dosage

How often?

What for?

55) Does the child:

Wear glasses? Yes No (Farsighted Nearsighted Other)

Use a hearing aid? Yes No

56) Within the past year, has the child had:

Results

A vision test? Yes No

A hearing test? Yes No

57) What is the child's :

Height _____ ft. _____ in.

Weight: _____ lbs.

58) When was the child's last medical check-up? _____

59) What therapies have been provided to the child?

- No therapies
- Occupational therapy
- Physical therapy
- Psychological therapy, counseling, or cognitive rehabilitation
- Speech therapy
- Other therapy: _____

FAMILY HISTORY

60) The child lives with:

- Biological parent(s) only Relatives Foster parents
- Biological parent and other Adoptive parents Institutional care
- Other placement: _____

61) The family's income is:

- under \$10,000 \$10,000-\$29,999 \$30,000-\$50,000 over \$50,000

62) What is the name of the child's biological mother? _____

- a. Is she living? Yes No If deceased, explain: _____
- b. Her age? _____
- c. What is her level of education? _____
- d. Her occupation? _____
- e. Does she live in the same house as the child? Yes No
- f. How often does she see the child? _____
- g. How involved is the mother in the child's upbringing? Very Somewhat Not at all

- h. Did the mother have a learning disability or other problems when she was in school?
 Yes No If yes, describe: _____
- i. What are the mother's hobbies? _____

- 63)** What is the name of the child's biological father? _____
- a. Is he living? Yes No If deceased, explain: _____
- b. His age? _____
- c. What is his level of education? _____
- d. His occupation? _____
- e. Does he live in the same house as the child? Yes No
- f. How often does he see the child? _____
- g. How involved is the father in the child's upbringing? Very Somewhat Not at all
- h. Did the father have a learning disability or other problems when she was in school?
 Yes No If yes, describe: _____
- i. What are the father's hobbies? _____

64) Please list the names, ages, and grade (or job) of the child's brothers and sister:

| Name | Age | Grade or job |
|------|-----|--------------|
|------|-----|--------------|

65) Has anyone in the child's biological family (including parents, grandparents, siblings, aunts & uncles) ever had any of the following:

| | Which relative? | Describe the problem briefly |
|---|-----------------|------------------------------|
| <input type="checkbox"/> Brain disease | _____ | _____ |
| <input type="checkbox"/> Developmental delay | _____ | _____ |
| <input type="checkbox"/> Epilepsy or seizures | _____ | _____ |
| <input type="checkbox"/> Learning disability | _____ | _____ |
| <input type="checkbox"/> Mental retardation | _____ | _____ |
| <input type="checkbox"/> Neurological disease | _____ | _____ |
| <input type="checkbox"/> Psychological problems | _____ | _____ |
| <input type="checkbox"/> Reading or spelling difficulties | _____ | _____ |
| <input type="checkbox"/> Speech or language problems | _____ | _____ |

66) Which of the child's biological relatives are left handed?

No one Mother Father Sibling(s) Grandparent(s)

67) What languages are spoken in the home? (list in order of the most frequent first)
1) _____ 2) _____

68) How is the child disciplined? _____

69) List the child's usual recreational activities and hobbies: _____

70) Have there been any major family stresses or changes in the past year (e.g. moving with change of school, divorce, significant illness, etc)?

Yes No If yes, explain: _____

How much stress have these changes caused the child? (circle one)

None

Mild

Moderate

Severe

SCHOOL HISTORY

71) The child's present school is: Name: _____

Address: _____

Phone: _____ Contact person: _____

72) Was the child ever held back to repeat a grade? Yes No

If yes, which grade? _____ Why? _____

73) Has the child ever been in a special class or provided with special services (e.g. resource room, EMR, learning disability class, etc.)? Yes No

If yes, describe the special class: _____

Is the child in this class or receiving special services now? Yes No

74) Does the child like school? Most of the time Some of the time Almost never

75) Does the child:

- | | | |
|--|------------------------------|-----------------------------|
| Have problems with other children in class? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Have problems making friends in school? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Have problems getting along with teachers? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Tend to get sick in the morning before school? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

76) Describe the teacher's concerns about the child's schoolwork or behavior:

77) What kind of grades has the child received in the past year?

- A's & B's B's & C's C's & D's D's & F's
or Outstanding Good Satisfactory Improvement needed Unsatisfactory
or Other grading system: _____
Are these grades a change from previous years? Yes No

78) In which subject(s) does the child do best? _____

79) Which subject(s) are the most difficult? _____

80) In the past year, how much school has the child missed due to illness or injury?

- Less than 2 weeks 2 to 4 weeks 5 to 8 weeks Over 8 weeks

Briefly describe the reasons if the child has missed a lot of school: _____

81) Does the child seem to have a "school phobia"? Yes No

If yes, explain: _____

PREVIOUS EVALUATIONS

82) Which of these tests or procedures have been done recently? Note any abnormal findings.

| Evaluation: | Check here if normal | Abnormal findings |
|--|--------------------------|-------------------|
| <input type="checkbox"/> Blood work | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Family physician or pediatrician office visit | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Hearing testing | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Lead level check | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Lumbar puncture or spinal tap | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Neurological exam or testing | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Psychological or neuropsychological testing | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> School testing | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Speech & language testing | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Vision testing | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> X-rays | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Other tests: | <input type="checkbox"/> | _____ |
| _____ | <input type="checkbox"/> | _____ |
| _____ | <input type="checkbox"/> | _____ |

83) What are the names of the physician, psychologist, school authority, or other professionals we may contact who are most familiar with the child's problems?

| | |
|-------------------|-------------------|
| Name: _____ | Name: _____ |
| Address: _____ | Address: _____ |
| _____ | _____ |
| Phone: _____ | Phone: _____ |
| Profession: _____ | Profession: _____ |

Parent of Guardian's signature

Date

THANK YOU FOR TAKING THE TIME TO CAREFULLY COMPLETE THIS QUESTIONNAIRE