Oakland Neuropsychology Center
Isabelle Beaulieu, Ph.D., Director
4190 Telegraph Rd, Suite 2700 • Bloomfield Hills, MI 48302
Phone: 248.644.9466 • Fax: 248.522.7365 • Website: OaklandNeuropsych.com

CHILD HISTORY FORM

INSTRUCTIONS TO PARENTS: Please fill out to best of your knowledge. Write N/A if not applicable to your child. Circle appropriate answers where indicated. Continue on attached blank paper if necessary and add any additional comments you wish to make.

Child's Name: _____ Birth Date: _____

Mother's Name: _____Father's Name: _____

Name/Relationship of Person Completing This Form:_____

Date: _____

Child's Primary Home Address: _____

City, State, Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Child's Secondary Home Address (if applicable): _____

City, State, Zip: _____

Home Phone: (____) _____

Father's Business Address: _____

City, State, Zip: _____

Business Phone: (____) _____ Cell Phone: (____) _____

Occupation: _____

Mother's Business Address: _____

City, State, Zip: _____

Business Phone: (____) _____ Cell Phone: (____) _____

Occupation: _____

Pediatrician's Name: _____

Address: _____

City, State, Zip: _____

Business Phone: (____) _____ Cell Phone: (____) _____

Referred by: _____ Occupation: _____

Reason for consultation: _____

_____

_____

_____

What do you think your child's problem is (if other than reason for consultation): _____

_____

_____

Pregnancies:
List in order of birth, including the client being seen in our clinic. If pregnancy ended in miscarriage, state at which month and why. If more than three, continue on reverse side.

Year	Length of Pregnancy	Birth Weight	Sex	Complications
____	_____	_____	____	_____
____	_____	_____	____	_____
____	_____	_____	____	_____
____	_____	_____	____	_____
____	_____	_____	____	_____

Was this child adopted? No ____ Yes ___ If yes, at what age? ____ Nationality _____

PREGNANCY & BIRTH HISTORY

Name of hospital: _____

Mother's age at delivery: _____ Father's age at delivery: _____ How many prior pregnancies: _____

How many prior miscarriages? ____ Threatened miscarriage? ____

Please answer the following questions about the child's mother during pregnancy.

	Yes	No		Yes	No
Procedures			Fertility specialist consulted		
Vaginal bleeding			Health problems		
Gestational diabetes			Hypertension		
Trauma			Anemia		
Toxemia			Fever or rash (e.g., flu or measles)		
Heart disease			Kidney disease		
Smoked			Virus		
Used illicit drugs			Drank alcohol		
Depression or emotional problems			Used antibiotics		
Injury			Blood incompatibility		

Please explain "yes" answers or list other concerns: _____

_____

_____

Medications, tobacco, alcohol, or drugs used by mother during pregnancy: _____

_____

	Yes	No	Details
Vaginal delivery			
Cesarean delivery			Reason:
Full-term delivery			
Premature delivery			Weeks gestation:
Baby's birth weight			Pounds Ounces
Labor was induced			
Forceps were used			
Multiple births in this pregnancy			If yes, this child's birth order:
Birth complications			
Baby breathed spontaneously			
Baby cried quickly			
Oxygen required			
Breathing problems			
Respirator used			How many hours/days: Apgar scores:
Baby in ICU nursery			Reason(s):
Baby's age at hospital discharge			
Baby went home with mother			
Mother was in hospital for days			
Child's medical problems after discharge (e.g., jaundice, fever, surgery, transfusion)			
Problems in first few months			
Post-partum depression			Weight gain (in pounds):
Baby received phototherapy			
Other complications:			

INFANCY

	Yes	No	Details
Baby had feeding problems			Describe:
Baby was colicky			How many months:
Baby required formula change			Describe:
Difficulties sucking			
Difficulties chewing			
Baby failed to gain weight			

Baby failed to grow normally			Describe:
Baby had weak cry			
Baby was normally active			If no, describe:
Baby was limp			
Baby was stiff			
Baby had tremors			
Baby had convulsions			Describe:

MOTOR DEVELOPMENT

Please list the age when the child:	**Age**		**Age**
Sat alone		Walked without holding on	
Fed self		Dressed self	
Tied shoes		Pedaled tricycle	
Rode bicycle		Swam	

Was your child slow to develop motor skills or awkward compared to siblings/friends (e.g., running, skipping, climbing, biking, playing ball)?_____

Handedness: Right _____ Left _____ Both _____ Explain: _____

Family history of left-handedness (list relatives): _____

Was physical or occupational therapy ever necessary? Yes ___ No ___ At what age(s): _____

_____

_____

LANGUAGE DEVELOPMENT

Please list the age when the child:	**Age**		**Age**
Babbled		Spoke first word	
Put 2-3 words together		Used good sentence structure	

	Yes	**No**	**Details**
Speech delays or problems			Describe:
Oral-motor problems			Describe:
Speech/language therapy needed			
Slow to learn alphabet			
Slow to name colors			
Slow to count			
Child displays appropriate eye contact			
Child points to show			

Other language(s) spoken in home (besides English) – please list: _____

Any other language your child is fluent in: _____

TOILETING DEVELOPMENT

	Age	Times/Week	Times/Month	Time of Day
Age toilet training started				
Age trained for urine				
Age trained for bowels				
Age at which it was controlled				
Urine accidents during day				
Soiling accidents				

Was there bed-wetting after initial toilet training? Yes ___ No ___

TEMPERAMENT

Please check all that describe your child in each age group (infancy, toddler, or preschool):

	Infant	Toddler	Preschool
Shy or timid			
Slow to warm up			
Stubborn			
Affectionate			
Daredevil			
Cautious			
Into everything			
Overactive			
Poor sleep			
Underachiever			
Wanted to be left alone			
More interested in things than people			
Falling spells			
Happy			
Aggressive			
Poor eating			
Tore up toys more than normal			
Rocking			
Head banging			

PAST MEDICAL HISTORY

	Yes	No	Age in years & months
Encephalitis or meningitis			
Head injury requiring medical attention			
Convulsions			
Loss of consciousness			
Measles			
German measles			
Mumps			
Chicken pox			
Strep throat			
Headaches / when they occur			
Abdominal pains & vomiting / when they occur			

Chronic constipation			
Vision problems / describe			
Hearing problems			
Frequent ear infections (between what ages)			
Hearing tubes placed			
Allergies or asthma			
Sleep difficulties			
Diabetes			
Eating difficulties / disorders (describe)			
Lead poisoning / toxic ingestion			
Seizures (associated with fever?)			
Epilepsy			
Staring spells			
Tics / twitching			
Repetitive / stereotypic movements (hand flapping)			
Head banging			
Self-injurious behavior			

PREVIOUS MEDICATIONS TAKEN FOR MORE THAN ONE MONTH

Name	Dose	Time Given	Reason Given
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRESENT MEDICATIONS

Name	Dose	Time Given	Reason Given
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SPECIALITY TESTS

	Age in Years & Months	Results
Eye examination		
Hearing examination		
EEG		
Other (list)		

Have you consulted any other medical specialists for your child? _____ If so, whom ? _____

Reason _____

Results _____

HOSPITALIZATION

Age _____ Reason _____

Age _____ Reason _____

List other illnesses _____

_____

PRIOR PSYCHOLOGICAL HISTORY

Has your child had any emotional adjustment or behavioral problems? _____

Describe at what age and type: _____

_____

_____

Has your child received any psychological or psychiatric treatment?_____

Reason _____

By whom?_____ Where? _____When? _____

Effectiveness? _____

Reason _____

By whom?_____ Where? _____When? _____

Effectiveness? _____

Reason _____

By whom?_____ Where? _____When? _____

Effectiveness? _____

Reason _____

By whom?_____ Where? _____When? _____

Effectiveness? _____

Have you consulted with any one else for the current problem?_____ Whom? _____

When? _____ Where? _____

FAMILY HISTORY

Please check all that apply and indicate relative.

	Who	What Kind
Neurological illness		
Seizures		
Psychiatric / psychological illness (e.g., depression)		
Psychiatric hospitalization		
Mental retardation		
Alcohol / drug abuse		
Learning difficulties		
Visual problems		
Hearing problems		
Speech problems		

Slowness in walking		
Slowness in talking		
Hyperactivity		
Difficulty with the law		
Does a specific disease run in your family? If yes, please describe:		
Does anyone in your family have similar problems as the child being seen in our clinic? Who?		

FAMILY EDUCATIONAL HISTORY

Under parents, list names of children in order of birth.

AGE EDUCATION (grade) OCCUPATION SCHOOL / BEHAVIOR PROBLEMS

FATHER _____

MOTHER _____

_____

_____

_____

_____

CHILD'S EDUCATIONAL HISTORY

Name of school: _____ Phone number: (____)_____

Address:_____ City/State/Zip: _____

Teacher's name: _____ Grade: _____

Type of school: Public_____ Private _____ Special _____

Placement: Regular _____ Resource _____ Special Education _____

List previous schools, dates attended, and indicate overall performance (academic and behavioral):

_____ Performance: Poor ____ Fair ____ Good ____

_____ Performance: Poor ____ Fair ____ Good ____

_____ Performance: Poor ____ Fair ____ Good ____

_____ Performance: Poor ____ Fair ____ Good ____

_____ Performance: Poor ____ Fair ____ Good ____

Grades repeated: _____ Grades skipped: _____ Expelled? _____ If yes, # of times _____

Any known learning disabilities? _____ Describe: _____

Has the child received special help privately (e.g., tutoring, coaching)? _____ Describe: _____

_____

_____

How often? _____ By whom? _____

Teachers report problems with:

Math		Reading		Spelling		Writing	
Following directions		Social adjustment		Attention / concentration		Hyperactivity	
Behavior		Test anxiety		Completing homework		Forgetting assignments	
Makes many careless errors		Noncompliance		Does your child like school? Yes ___ No ___			

Describe any problems noted above: _____

_____

_____

How does the school describe this child's classroom behavior? _____

_____

_____

_____

What does this child do best in at school? _____

_____

_____

Has any psychological testing been done in the school? Yes ___ No ___ Were you told results? _____

_____

_____

What recommendations were made? _____

_____

Has your child attended any other schools? _____

School name _____Yrs. attended _____

School name _____Yrs. attended _____

School name _____Yrs. attended _____

SOCIAL HISTORY

Who lives at home? _____

What language is spoken in the home? _____

Are there significant marital conflicts? Yes ____ No ____ If yes, please describe: _____

_____

Are there significant conflicts between child and parents? Yes ____ No ____ If yes, please describe:

_____

Are there significant conflicts between the children? Yes ____ No ____ If yes, please describe:

_____

Do parents agree on how to discipline the child? Yes ____ No ____

Who disciplines and how?_____

How does child respond to discipline? _____

Which of the following, if any, describe(s) this child's interactions with peers?

No friends		Few friends	
Loses friends		Mean, aggressive	
Too shy, timid		Trouble making new friends	
Bossy, controlling		Risky behaviors	

Does child have a best friend? Yes ___ No ___ Is this friend of the same sex? Yes ____ No ____

What special interest does the child have? _____

Further comments on homework, academic functions, and peer relations: _____

_____

_____

_____

How does the child perform athletically?_____

_____

List all moves during the child's lifetime and describe any problems relating to adjusting to new home, neighborhood or school.

From _____ To: _____ Age _____

Problems _____

From _____ To: _____ Age _____

Problems _____

From _____ To: _____ Age _____

Problems _____

Have there been any prolonged separations from one or both parents for the child? Yes ____ No ____

List each, describing reason for separation, length of time and age of child when separation took place.

_____

_____

_____

What have been the sleeping arrangements for the child from infancy up to the present time? _____

_____

_____

How long was the child in the parental bedroom?_____

Has (s)he or does (s)he now share a bed with a sibling? _____ Parent? _____

Is the child's problem getting worse? _____ Describe _____

_____

_____

_____

_____

Any concerns not listed? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What are your hopes for the outcome of the evaluation? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____