History Form | School Age

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(While this is a lengthy form obtaining this information is important to us please complete as accurately as possible. Thank You!)

Today's Date: _____

IDENTIFYING INFORMATION:

Child's Name: _____

Date of Birth: _____ Age: _____

School: _____ Grade: _____

Parent/Guardian Names: _____

Stepparents Involved: _____

Child lives with: _____

Other family members (list ages and in/out of home):

Biological siblings: _____

Step Siblings: _____

Others: _____

Primary language spoken in home: _____

REASON FOR REFERRAL:

Referred by: _____

Reason for visit: _____

When was the reason first noticed? _____

Previous diagnosis (list type and dates): _____

Previous evaluations (what for and when): _____

Current/previous treatment (where and dates): _____

What are your concerns about your child? _____

What question may we try and help you answer by having your child seen here? _____

Where would you like us to send your results? _____

MEDICAL and ALLIED HEALTH PROFESSIONAL CONTACTS:

Current Pediatrician: Group or practice:

Other Medical Physicians, Optometrists or Specialists: (Speech, Physical, Occupational, Tutors…)

Name: Group or practice:

Name: Group or practice:

Name: Group or practice:

PREGNANCY/BIRTH HISTORY:

Please describe any significant pregnancy or birthing experiences:

Were you prescribed medications (other than vitamins) during your pregnancy: yes no

Did you use illicit/street drugs or alcohol while pregnant: yes no If yes, what?_____

Was your delivery on time late early

Was your delivery vaginal C-section

Were there complications associated with delivery yes no
If yes, briefly explain_____

CHILDHOOD MEDICAL HISTORY:

Check any of the following that apply. List age and explanation:

Item	✓	Age	Explanation
Regular medication (please list)			
Convulsions/seizures			
Meningitis			
Encephalitis			
Injury to head & loss of consciousness			
Fainting spells			
Measles			
Chronic illnesses			
Constipation			
Allergies			
Chronic cough			
Asthma			
Chronic Pain			
Stomach or intestinal disorders			
Reactions to immunizations (specify)			
Chronic ear infections			
Hearing exam/poor hearing			
Vision exam/poor eyesight			
Eating disorders			
Sleep disorders			
Other (wear glasses or hearing aids…)			

Has your child had any medical hospitalizations? Yes No If yes, why?

_____

_____

Please list your child's current medications?

_____

_____

FAMILY HISTORY:

Check any of the following that apply. List relationship (i.e. mother, brother) and explanation:

Family history of…	✓	Relationship	Explanation
Learning disorders (reading, math, …)			
Emotional disorders (depression, anxiety,...)			
Genetic disorders			
ADHD/ADD			
Speech/language disorders			
Substance abuse (drugs/alcohol)			
Grade Retention			

MOTOR DEVELOPMENT:

Check any that apply. List age that your child achieved this skill:

Skill	Yes	Not Yet	Age	Skill	Yes	Not Yet	Age
Crawled				Rode Bicycle			
Walked alone				Bladder Trained			
Undressed himself/herself				Bowel Trained			
Dressed himself/herself				Used writing tools such as pencil or crayon			
Skipped				Used Scissors			
Tied shoes				Can your child run with good coordination for age			
Rode Tricycle				Does your child often walk on tiptoes			

SPEECH AND LANGUAGE DEVELOPMENT:

Describe VERBAL BEHAVIOR:

At HOME do you notice that your child has difficulty telling you a story or giving you information? Yes No

Do you notice that your child often repeats words over and over again or repeats your words? Yes No

Can you understand your child's speech? Yes No Can others? Yes No

Does your child stutter? Yes No

If yes, describe:

_____

_____

Estimate vocabulary size: 0 words 1-25 words 25-50 words 50-100 words over 100 words

Describe LISTENING BEHAVIOR:

Does it seem to you that your child has difficulty listening? Yes No

At school does your child usually follow directions only after teacher repeats him/herself more than once? Yes No

Can your child follow 3-step directions? Yes No

Can your child answer complex questions? Yes No

Can your child tell about past events or experiences? Yes No

Does the teacher tell you that your child is often not listening or paying attention? Yes No

Does your child have difficulty listening when at home? Yes No

Is your child often off task? Yes No

EATING/SWALLOWING BEHAVIORS:

Does your child have a good appetite?	Yes	No
Is your child a picky eater?	Yes	No
Does your child refuse trying new foods?	Yes	No
Does your child drool?	Yes	No
Does your child refuse any food tastes, textures, or temperatures?	Yes	No

If yes, describe: _____

SOUNDS / TEXTURES / LIGHT / SMELLS / COORDINATION

	YES	NO
Does your child often shield their eyes from the sun or bright lights?		
Does your child complain about tags on clothing?		
Does your child often seem unaware of "normal" touch or pain?		
Is he/she prone to touching others too soft or too hard or complain that others touch is too soft….?		
Does he/she seem overly sensitive to sounds (vacuums, blenders, a distant ambulance, a toilet flushing….)?		
Does your child frequently chew on things (straws, shirts, pencil and pen tips, cups….)?		
Does your child often walk on their tippy toes?		
Does your child dislike or hate being tickled or cuddled?		
Does your child have difficulty dressing themselves more so than his or her age mates?		
Is he/she prone to often smelling people, food or objects?		

ACADEMIC/EDUCATION DEVELOPMENT:

Current School: Phone:

Address: City: County:

Current Grade: Teacher:

Most liked subjects:

Least liked subjects:

What are your child's typical grades? _____

Has your child repeated a grade? Yes No If yes, which grade? _____

Is your child in Special Education Yes No If yes, why (SLD, ADHD, Autism, Vision, Hearing, Intellectual Disability)

Is the school's SP Ed Program meeting your child's needs? Yes No

Have your child's grades recently dropped? Yes No

If yes, why do you think this has happened? _____

Does homework take an unreasonable time to complete? Yes No How long would you estimate: _____

Does your child have friends at school? Yes No If not, do you think that they want friends? _____

Please describe any difficulties your child has relating with peers, making or keeping friends

_____

_____

School History:

Prior Schools attended	Years

Check any of the following that apply:

Academic behaviors	✓
Poor listening skills	
Poor handwriting, letter formation	
Poor memory, short-term and long-term	
Right-left confusion, directionality problems	
Poor computational / Math skills	
Late letter recognition	
Poor word recognition skills	
Poor reading comprehension	
Poor phonetic base	
Difficulty getting ideas on paper	
Problems in math	
Word problems and calculations	
Poor spelling in day-to-day assignments	
Problems with classwork or homework completion	
Procrastinates	
Forgets assignments/materials	
Poor attention and concentration	
Trouble keeping materials organized	
Conflict with teacher	
Certified for special education (LD resource help, MR, Speech, etc.)	
Drop in group achievement tests	
Repeated grade – please list which grade(s):	
Expulsion/suspension from school	

Check any of the following that apply:

Behaviors	✓	**Explanation**
Difficulty sleeping □ / Nightmares □		
Enuresis (wetting) □ / Encopresis (soiling) □		
Sucks thumb		
Difficult to discipline		
Temper tantrums		
Sad □ / Cries easily □		
Unusually active, fidgety / Bites nails		
Unusually inactive, apathetic		
Difficulty with brothers and/or sisters		
Difficulty in getting along with other children		
Lacks age appropriate play skills		
Avoids peer interactions or other unfamiliar social contacts		
Socially inappropriate		
Inattentive □ / Impulsive □ / Distractible □		
Anxiety □ / Separation anxiety □		
Difficulty with transitions		
Resists changes in environment		
Argumentative		
Destructive		
Cruel and if so to people or animals and how?		
Self-conscious / easily embarrassed		
Motor and/or vocal tics		

Oddities of speech or motor movement		
Low productivity at school, work, home		
Overly dependent/helpless		
Chronically tired or irritable		
Headaches, stomachaches, nausea		
Odd/bizarre ideas		
Has poor personal hygiene		
Other		

LEGAL

Has your child always been in your care Yes No If no, whose care has he/she been in? _____

Has Social Services ever investigated abuse/neglect allegations removed this child from their home or indicated that this child has been the victim of abuse/neglect? Yes No If yes, please tell us about this

_____

_____

SOCIAL / EMOTIONAL / BEHAVIORAL DEVELOPMENT:

Who generally disciplines the child? _____

What methods are used? _____

Do parents agree on methods of discipline? Yes No

What effect does your discipline have on your child? _____

What seems to best calm down your child when he/she is tearful or angry? _____

ADDITIONAL COMMENTS:

_____

_____

_____

_____

Please note any major changes in your child's family, school, social life in the last 6-9 months, which could be important. If there is any specific information which has not been requested on this form but which would help us in understanding your child's problems, please include here:

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this form. While lengthy, it will help us serve your family better. If you have other relevant documentation related to your concerns, please bring copies of records to your first appointment.