

DEVELOPMENTAL AND HEALTH HISTORY INFORMATION

Name of Patient _____ Date of Birth ___/___/___ Age _____

Parent(s) Name _____ Age _____ Highest Education _____

Parent(s) Name _____ Age _____ Highest Education _____

Legal Guardian _____

Person completing form _____

FAMILY HISTORY

Family history can often be helpful in understanding a child's problems.

Please check any box that applies:

<i>Has anyone in the family had:</i>	<i>Siblings</i>	<i>Parents</i>	<i>Extended Family</i>
Motor problems?			
Reading problems?			
Speech/language problems?			
School/learning problems?			
Alcohol/drug problems?			
Anxiety, depression, other psychological disorders?			
Seizures/epilepsy?			
Attention problems/hyperactivity?			

Please list all family members (in or out of house) and other people currently in the house:

NAME	RELATIONSHIP	AGE	CURRENTLY IN HOUSE?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parents are: ___Married ___Living together ___Divorced ___Separated ___Widowed

BIRTH HISTORY

Was the pregnancy normal? YES NO

Was the labor and delivery normal? YES NO

(If no to either above, please describe) _____

Birth weight _____ Full term? YES NO
 (If premature, how many weeks early _____)

During pregnancy with this child, did the mother:

Drink alcohol? YES NO Take any drugs? YES NO

Smoke cigarettes? YES NO Take any medications? YES NO

(If yes, list medications taken _____)

During hospital stay, did baby have any problems? YES NO

(If yes, please describe _____)

Were there any problems in the first year of life? YES NO

(If yes, please describe _____)

DEVELOPMENTAL HISTORY:

How old was the child when s(he):

	Approximate Age	(If not sure, please estimate)		
Sat?	_____	Early	Average	Late
Walked?	_____	Early	Average	Late
Toilet trained?	_____	Early	Average	Late
Said first words?	_____	Early	Average	Late
Began using sentences?	_____	Early	Average	Late

During the first twelve months, was this child:

	YES	NO		YES	NO
Difficult to get to sleep?			Irritable?		
Difficult to put on a schedule?			Alert?		
Easy to comfort?			Affectionate?		
Overactive/in constant motion?			Sociable?		

SPEECH AND LANGUAGE

Has his/her hearing ever been tested? YES NO
Last hearing/audiology evaluation: PLACE _____ DATE _____
RESULTS _____

Does this child have a history of frequent ear infections? YES NO

Has s(he) ever had tubes placed in her/his ears? YES NO

Does this child have:
Any speech problems/difficulty speaking? YES NO
Have trouble understanding what is being said to him/her? YES NO

Has (s)he ever had a Speech and Language Evaluation? YES NO
(If yes, where _____ When _____)
RESULTS _____

Has (s)he ever had Speech/Language Therapy? YES NO

Is (s)he currently receiving Speech/Language Therapy? YES NO
(If yes, where _____ Frequency _____)

MOTOR SKILLS

Does this child have fine motor problems (writing, drawing)? YES NO

Has (s)he ever had Occupational Therapy (OT) evaluation? YES NO

Is (s)he currently receiving OT services? YES NO
(If yes, where _____ Frequency _____)

Does (s)he have any gross motor problems (walking, running)? YES NO

Has (s)he ever had a Physical Therapy (PT) evaluation? YES NO

Is (s)he currently receiving PT services? YES NO
(If yes, where _____ Frequency _____)

Does this child use any adaptive devices (braces)? YES NO
(If yes, please describe _____)

VISION

Has this child ever been to an eye doctor? YES NO Most recent date _____

Does this child wear glasses? YES NO
(If yes, why _____)

* **Important: if a child wears glasses, please bring them to the appointment**

MEDICAL HISTORY & CURRENT MEDICAL

Is this child generally in good health? YES NO
(If no, please describe _____)

Does this child have allergies? YES NO (If yes, to what _____)

Is (s)he currently taking any medications? YES NO
(If yes, name of medication(s) _____ Reason _____
_____ Reason _____
_____ Reason _____

Did this child ever have a head injury or concussion? YES NO
Has (s)he ever had a high lead level or lead poisoning? YES NO
Does (s)he have a seizure disorder? YES NO
Has this child ever had any serious illness or hospitalization? YES NO
(If yes, please describe _____)

Does this child see any medical specialists (neurologists)? YES NO
(If yes, who _____ Reason _____
_____ Reason _____

SCHOOL HISTORY

Name of school/day care _____ Grade _____

Address of school _____

Has (s)he ever repeated a grade? YES NO If yes, which grade(s) _____

Is there an Ed. Plan (IEP)? YES NO

Has (s)he ever received special/extra help in school? YES NO

Is (s)he currently receiving special/extra help in school? YES NO

If yes, please circle types of services being received:

Occupational Therapy Resource Room Speech/Language Reading

Physical Therapy In-class LD Adaptive Phys. Ed Counseling

Other (specify) _____

Has (s)he ever had a developmental, psychological, or educational evaluation? YES NO
(including school CORE evals.)

If yes, where was the most recent? _____ Date _____

***IMPORTANT; PLEASE SEND MOST RECENT EVALUATION, REPORTS AND EDUCATIONAL PLAN (IEP) WITH THIS PACKET**

BEHAVIOR/MENTAL HEALTH

Do you feel that this child exhibits any of the following symptoms more often than is typical for a child of his/her age? (Please put a check in front of any that apply)

	Often touchy/easily annoyed		Often bullies/threatens		Often irritable
	Often defies adult rules		Initiates physical fights		Changes in appetite
	Often angry/resentful		Ever been arrested		Diminished interest
	Often argues with adults		Physically cruel to others		Sleep problems
	Often loses temper		Physically cruel to animals	—	Restlessness or slowed down
	Blames others for mistakes		Difficulty maintaining friendships		Fatigued/low energy
	Deliberately annoys		Destroys property		Feels worthless
	Often spiteful/vindictive		Deliberately sets fires		Becomes tearful easily
	Refuses to go to school		Lies often		Often sad
	Repeated nightmares		Steals		Indecisive/can't think
	Unusual fears		Has run away		Thinks about death
	Panic attacks		Extreme mood swings		Talks about suicide
	Self-conscious/clings		Does not show emotions		Hurts self
	Excessive need for reassurance		Overreacts to touch/noise		Currently uses drugs
	Somatic complaints (headache, stomach)		Strange or bizarre ideas		Used drugs in the past
	Worry of future events		Gets upset by changes in routine		Currently drinks beer or alcohol
	Repeats certain actions		Poor social interactions		Used beer or alcohol in past
	Can't stop thinking about things		Self-injurious behavior		Excessive preoccupation with objects or ideas
	Motor or vocal tics				

Please place a check mark in the column which best describes the child:

	Not at all	Just a little	Pretty much	Very much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork or other activities				
2. Often has difficulty sustaining attention in tasks or play activities				
3. Often does not seem to listen when spoken to directly				
4. Often does not follow through on instructions and fails to finish schoolwork, or chores (not due to oppositional behavior failure to understand directions)				
5. Often has difficulty organizing tasks and activities				
6. Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)				
7. Often loses things necessary for tasks or activities (toys, school assignments, pencils, or books)				
8. Is often easily distracted by extraneous stimuli				
9. Is often forgetful in daily activities				
10. Often fidgets with hands or feet or squirms in seat				
11. Often leaves seat in classroom or in other situation in which remaining seated is expected				
12. Often runs about or climbs excessively in situation where it is inappropriate (in adolescents, may be limited to subjective feelings of restlessness)				
13. Often has difficulty playing or engaging in leisure activities quietly				
14. Is often "on the go" or often acts as if "driven by a motor"				
15. Often talks excessively				
16. Often blurts out answers before questions have been completed				
17. Often has difficulty waiting turn				
18. Often interrupts or intrudes on others (butts into conversations or games)				

Child's Name: _____

~Relevant Contact Persons~

In order to provide the most comprehensive mental health services possible, it is important to gather information from a wide variety of sources. This often includes having caregivers' permission to exchange information with teachers, physicians, past therapists, and others involved in the child's and family's life.

Please indicate below the names and contact information for the individuals or agencies who might be able to provide further relevant information. This, however, **does not allow** Slatoff and Ward to contact these people. This information will simply be used to complete formal release forms which, if you choose to sign, will then allow Slatoff and Ward to contact the individuals or agencies so designated.

55. SCHOOL or PLACE OF EMPLOYMENT:

_____ <i>Name of Individual or Agency and Contact Person, as appropriate</i>			
_____ <i>Address</i>	_____ <i>City</i>	_____ <i>State</i>	_____ <i>Zip</i>
(_____) _____ <i>Phone or Fax</i>	(_____) _____ <i>Phone or Fax</i>		

56. PEDIATRICIAN or PHYSICIAN:

_____ <i>Name of Individual or Agency and Contact Person, as appropriate</i>			
_____ <i>Address</i>	_____ <i>City</i>	_____ <i>State</i>	_____ <i>Zip</i>
(_____) _____ <i>Phone or Fax</i>	(_____) _____ <i>Phone or Fax</i>		

57. FORMER THERAPIST:

_____ <i>Name of Individual or Agency and Contact Person, as appropriate</i>			
_____ <i>Address</i>	_____ <i>City</i>	_____ <i>State</i>	_____ <i>Zip</i>
(_____) _____ <i>Phone or Fax</i>	(_____) _____ <i>Phone or Fax</i>		

58. OTHER - SPECIFY:

_____ <i>Name of Individual or Agency and Contact Person, as appropriate</i>			
_____ <i>Address</i>	_____ <i>City</i>	_____ <i>State</i>	_____ <i>Zip</i>
(_____) _____ <i>Phone or Fax</i>	(_____) _____ <i>Phone or Fax</i>		