"Specialist Care for Every Child"

Child and Adolescent Clinic
www.CandAC.com

Attention Learning and Behavior Disorder

Expanded Childhood History

Please Use Black Ink

Child's Name: _____Date _____

Birth Date: _____ Age: _____ Sex: _____

Person Completing Form: _____ Relationship to Child: _____

Child's School: _____

Grade: _____ Special Placement (if any): _____

Child is presently living with:

____ Natural Mother ____ Natural Father ____ Stepmother ____ Stepfather

____ Adoptive Mother ____ Adoptive Father ____ Foster Mother ____ Foster Father

____ Other (Specify) _____ Number of children in home _____

Non-residential adults involved with this child on a regular basis: _____

_____

_____

Who suggested that your child be evaluated:

Name: _____ Phone: _____

Relationship to child: _____

Briefly state main behavioral and learning problems of this child: _____

_____

_____

_____

_____

_____

Patient's Name _____

PARENTS

MOTHER: _____

Occupation: _____ Work Phone: _____

Age: _____ Age at time of pregnancy with patient: _____

School: Highest grade completed: _____

Learning problems: _____

Attention problems: _____

Behavior problems: _____

Medical Problems: _____

Have any of the mother's blood relatives experienced problems similar to those your child is experiencing? If so, describe: _____

_____

_____

_____

FATHER: _____Age:_____

Occupation: _____Work Phone: _____

School: Highest grade completed: _____

Learning problems: _____

Attention problems: _____

Behavior problems: _____

Medical Problems: _____

Have any of the father's blood relatives experienced problems similar to those your child is experiencing? If so, describe: _____

_____

_____

_____

SIBLINGS:

Name	Age	Medical, social, or school problems
1.		
2.		
3.		
4.		
5.		

Patient's Name _____

ADDITIONAL FAMILY HISTORY

Indicate if any of the patient's parents, brothers, sisters, aunts, uncles, grandparents, or first cousins is affected by any of the following conditions:
(Please circle condition if answer is yes)

1. Mental Retardation
2. Seizures
3. Blindness
4. Deafness
5. Early Death
6. Thyroid Disease
7. Depression
8. Schizophrenia
9. Manic/Depressive Illness
10. Any Psychiatric Illness
11. ADD with Hyperactivity
12. ADD without Hyperactivity
13. Tourette's Syndrome

PREGNANCY

Complications:

Excessive vomiting: _____ Hospitalization required: _____

Excessive staining/blood loss: _____ Threatened miscarriage: _____

Infection(s) (specify): _____

Toxemia: _____ Operations (specify): _____

Other illness(es) (specify): _____

Smoking during pregnancy: _____

Alcohol consumption during pregnancy: _____

Describe if greater than occasional drink: _____

Medications taken during pregnancy: _____

Other "recreational" drugs: _____

X-ray studies during pregnancy: _____

Duration of Pregnancy:

□ Premature # Weeks: ____ □ Term □ Postdates # Weeks: ____

DELIVERY

Where: _____ Your Doctor's Name: _____

Type of Labor: □ Spontaneous □ Induced Duration _____hours

Type of Delivery: □ Normal □ Breech □ Cesarean

Complications: □ Cord around neck □ Hemorrage □ Infant injured during delivery

□ Other _____

Birth Weight: _____

POST DELIVERY PERIOD

□ Jaundice □ Cyanosis (turned Blue) □ Incubator Care

□ Infection (specifiy): _____

Number of days infant was in the hospital after delivery: _____

Patient's Name _____

INFANCY PERIOD

□ Breast-fed How long? _____ □ Formula What type? _____

Did your child have any special problems during the first year or so of life? _____

_____

_____

_____

MEDICAL HISTORY

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information:

Operations: _____
Hospitalization for illness: _____
Head injuries: _____
Convulsions: _____ with fever _____ without fever _____
Eye problems: _____ Ear problems: _____
Allergies or asthma: _____
Poisoning: _____
Sleep problems: _____
Appetite problems: _____

PRESENT MEDICAL STATUS

Present illness for which child is being treated: _____

Medications child is currently taking on ongoing basis: _____

_____

DEVELOPMENTAL MILESTONES

How old was your child when he/she walked independently? _____ Talked? _____
Was toilet trained? _____

Do you recall having any special concerns about your child's early motor or language development? _____

COORDINATION

Do you have any current concerns about your child's current level of coordination or athletic ability

_____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his or her age? If not, why? _____

_____

_____

How would you rate your child's overall level of intelligence compared to other children of the same age? □ Below average □ Above Average □ Average

SCHOOL

Your child's school teacher will have a separate form to complete

Do you have any special concerns about your child's academic performance? _____

_____

_____

_____

When did these concerns initially develop? _____

_____

_____

Do you have concerns about your child's behavior at school? _____

_____

_____

_____

When did these concerns initially develop? _____

_____

_____

PEER RELATIONSHIPS

Does your child seek friendships with peers? _____

Is your child sought by peers for friendship? _____

Does your child play with children primarily his/ her own age? _____ Younger? _____ Older? ____

Describe briefly any problems your child may have with peers: _____

_____

_____

_____

HOME BEHAVIOR

Does your child create more problems, either purposeful or nonpurposeful, within the home setting, than his or her siblings? _____

_____

_____

Does your child have difficulty benefiting from his experiences? _____

Types of discipline you use with your child: _____

_____

Is there a particular form of discipline that has proven effective? _____

_____

Have you participated in a parenting class or read books concerning discipline and behavior management? _____

_____

INTEREST AND ACCOMPLISHMENTS

What are your child's main hobbies and interests? _____

_____

_____

What are your child's areas of greatest accomplishments? _____

_____

_____

What does you child enjoy doing most? _____

_____

_____

What is your child's most positive quality? _____

_____

_____

List names and addresses of any other professionals consulted regarding your child's behavior, including family physician or pediatricians:

1. _____
2. _____
3. _____
4. _____
5. _____

Patient's Name _____

PARENTAL ASSESSMENT OF CHILD'S EMOTIONAL LEVEL

Rate on a scale of 1 to 10 (with 1 being the lowest or worst and 10 being the best or highest)

	Poor									Excellent
How do you see your child's social skills?	1	2	3	4	5	6	7	8	9	10
	Sad									Happy
How do you see your child's mood?	1	2	3	4	5	6	7	8	9	10
	Angry								Easy Going	
How do you see your child's anger level?	1	2	3	4	5	6	7	8	9	10
	Low									High
How do you see your child's self-esteem?	1	2	3	4	5	6	7	8	9	10

Has your child ever caused a major destruction of property, seriously injured another person, or seriously injured or killed an animal? _____

_____

_____

_____

Has your child ever broken the law and been involved with juvenile legal system because of vandalism, shoplifting, theft, assault, or any other crime? _____

_____

_____

_____

ADDITIONAL REMARKS

Please write any additional remarks you may wish to make regarding your child: _____

_____

_____

_____

_____

_____

_____

_____

_____

Please return to our office as soon as completed. Thank you!