Pediatric History Questionnaire

By completing this questionnaire *prior* to your appointment, you will be helping me to better understand your questions and the concerns that are affecting your child and your family. This will also provide me with a great deal of important information which will allow me to work with you more effectively. Some of the items may pertain to children younger or older than your child, so focus your attention on those items that are most appropriate. If you do not know or remember certain information, don't worry, and If you would rather talk to me in person about an item, you can leave it blank.--we can discuss these items (and the rest of the questionnaire) during your first appointment when we go over the questionnaire together.

Child's name: _____ Nickname: _____ Grade: _____

Date of birth: _____ Age of child: _____ Sex: _____

Handedness: _____

Parent(s) name(s): _____

Street Address: _____

(City) _____ (State) _____ (Zip) _____

Telephone: Home _____ Work _____

Name of person completing form: _____

Relationship to child: _____

Date form completed: _____

Are you this child's legal guardian? ___ Yes ___ No

If you are not the guardian, do you have written consent documenting your right to seek treatment for this child? ___Yes ___ No

Your child's *primary* language (i.e., the language he/she uses most often)? _____

Is this your child's *first* language (the language he/she learned and used as a very young child)? __yes __ no

If no, what was your child's *first* language? _____

Please list the languages spoken at home (in order of use) _____

Has your child had an evaluation by at school psychologist? ___Yes ___ No
When?

I. Purpose of Evaluation

Who suggested you get this evaluation?
Name: _____ Telephone Number: _____

Address: _____

_____

What questions would you like the evaluation to address?:
1.

2.

3.

4.

When did you first become aware of these problems?

What seems to help the problems/What seems to make the problems worse?

What evaluations has the child had? (If any please be sure to bring copies to the evaluation.)

- ❑ No previous evaluations
- ❑ Psychological or neuropsychological testing
- ❑ Speech and language testing
- ❑ Neurological examination or testing
- ❑ School testing/Educational Assessment
- ❑ Psychiatric Evaluation

When? _____

_____

What diagnoses were provided and do you agree with the diagnosis?

Diagnosis	Given by who?	Child was how old?	Do you agree?

In what way are you hoping that I can be helpful with your child's current difficulties?

What do you consider to be your child's best qualities or strengths?

II. Family History

Mother's name: _____ Age: _____

Highest level of education completed: _____ Occupation: _____

Place of employment: _____

Work hours: _____ Work phone: _____

Father's name: _____ Age: _____

Highest level of education completed: _____ Occupation: _____

Place of employment: _____

Work hours: _____ Work phone: _____

Step-parent's name (if applicable): _____ Age: _____

Highest level of education completed: _____ Occupation: _____

Place of employment: _____

Work hours: _____ Work phone: _____

Parents are:

Married:	_____	Date:
Separated:	_____	Date:
Divorced:	_____	Date:
Unmarried:	_____	Date:
Widowed:	_____	Date:

If parents are divorced, who has legal custody? _____

If parents are separated or divorced, please describe physical custody and visitation arrangements?

_____

_____

Please list the persons who are currently living in the home with the child:

Name	Sex	Age	Relationship to Child	Grade

Please list any family members who are no longer at home:

Name	Sex	Age	Relationship to child	When did they leave?

Is this child a foster child? Yes _____ No _____ Is this child adopted? Yes _____ No _____

If a foster child or adopted, at what age was the child placed with you? _____

If a foster child or adopted, has this been discussed with the child? Yes _____ No _____

If adopted, when was adoption legally finalized? _____

If a foster child or adopted, how many placements occurred prior to being placed in your home?_____

If there have been previous placements, please list all of the child's placements and length of placement_____

How long has the child been living in the current home or apartment? _____

How many times has your child been moved during the past 3 years? _____

Who provides care for your child while you are at work (if applicable)? _____

Please list anyone in the family who is left-handed or "mixed-handed:" _____

_____

Please indicate if anyone in the patient's immediate or extended family (parent, grandparent, brother/sister, uncle/aunt, cousins) has had any of the following?
(if you need more room, please add more comments below this section)

	Yes	Who?	Explain
Learning problem (e.g., reading, math)	____	_____	_____
		_____	_____
Language difficulties	____	_____	_____
Hyperactivity (or "ADHD")	____	_____	_____
Emotional Disturbance (please specify: e.g., depression, bipolar disorder, anxiety, obsessive compulsive disorder, schizophrenia, etc.)	____	_____	_____
		_____	_____
		_____	_____
Substance use problems (including alcohol)	____	_____	_____
Seizures/Epilepsy?	____	_____	_____
Neurological disease?	____	_____	_____
Mental Retardation?	____	_____	_____
Any genetic disorders?	____	_____	_____
Similar problems to patient?	____	_____	_____
History of sexual/physical	____	_____	_____

abuse?

III. Birth History

This section is to be completed by the caregiver most familiar with the child's history

(If this child is an adopted/foster child, please complete according to your knowledge of birthmother and pregnancy history)

Please indicate the following:

Number of pregnancies the child's mother has had: _____
- Number of live births _____
- Number of stillbirths _____
- Number of miscarriages _____

Number of living children _____

Number of deceased children _____

This child was the product of pregnancy number _____

Did you receive regular medical care during this pregnancy? Y_____ N_____

Did you have any problems during the pregnancy? Y_____ N_____

If yes, please describe the problem and the time it occurred during the pregnancy (such as diabetes, excessive vomiting, bleeding, high blood pressure, toxemia, weight loss, fever, accidents): _____

_____

If yes, did you require hospitalization or were you placed on bed rest? Y_____ N_____

Please explain:

_____

_____

What medications (prescribed or over the counter did you take while pregnant? _____

_____

Did you use any of the following during pregnancy?:

- ❑ Alcohol
- ❑ Marijuana
- ❑ Tobacco
- ❑ Caffeine (coffee, colas, etc.)
- ❑ Other drugs (cocaine, heroin, etc.)
- ❑ None

Was this child born: ❑ Early (when?)_____ ❑ On time (38-42 weeks) ❑ Late (when?)_____

Labor was: ❑ spontaneous ❑ induced

Type of delivery: ❑ normal/vaginal ❑ breech ❑ Caesarean

How long did labor last in hours? _____

What was the child's birth weight?_____

Were there any problems with the delivery? Y_____ N_____

If yes, please describe the problems (e.g., emergency Cesarean section, slow heart rate, fever, cord around neck, etc.). _____

_____

Apgar scores (if known): 1 minute:_____ 5 minutes: _____

Did your baby require any special care shortly after birth? Y_____N_____
If yes, please describe the type of care (e.g., phototherapy, blood transfusions, oxygen, incubator, medications, etc.)

_____

_____

How long after birth was the baby taken home? _____

IV. Developmental History

Were any of the following problematic during infancy and/or toddler period?:

❑ Did not enjoy cuddling ❑ Was not calmed by being held ❑ Colic
❑ Excessive restlessness ❑ Diminished sleep
❑ Constantly into everything ❑ Excessive number of accidents

Motor Skills-My child:

Crawled	❑ Early	❑ Average (6-9 months)	❑ Late	❑ Not Yet
Walked alone (2-3 steps)	❑ Early	❑ Average (9-15 months)	❑ Late	❑ Not Yet

Which hand does your child use most? ❑ Right ❑ Left ❑ Uses both equally

Language Abilities-My child:

Said single words	❑ Early	❑ Average (10-14 months)	❑ Late	❑ Not Yet
Used two-word sentences	❑ Early	❑ Average (14-20 months)	❑ Late	❑ Not Yet

Any current or past problems with (if so please describe below):

❑ Language expression (talking) ❑ Understanding directions ❑ Social Functioning
❑ Riding a bicycle ❑ Buttoning clothing ❑ Tying shoelaces
❑ Running ❑ Throwing/Catching ❑ Other athletic abilities

❑ Early School Skills (ABC's, colors) ❑ Reading ❑ Writing/Drawing

---

Has this child had difficulty separating? Y_____ N_____
If yes, at what age: _____

Did your child have any difficulties with early bonding? Y_____ N_____

Is your child toilet trained? Y_____ N_____
If yes, at what age: _____

Does your child have toileting accidents during the day? Y_____ N_____
If yes, how often: _____

Does your child have toileting accidents at night? Y_____ N_____
If yes, how often: _____

Has your child had any sleeping difficulties? Y_____ N_____
If yes, please describe: _____
_____

Does your child snore? Y_____ N_____

Has your child had any eating difficulties? Y_____ N_____
If yes, please describe: _____
_____

V. Medical History

When was your child's most recent physical?_____
Were there any medical concerns at this time (if yes, please describe) _____ Y_____ N_____

_____

Has your child experienced any of the following	At what age?	Nature of condition?	Treatment/Complications?
hospitalization			
surgery			
serious accident			
head injury(ies)		__loss of conscious-ness __ nausea/vomiting __ dizziness __ loss of function other:	
seizures or epilepsy			
exposure to lead			
allergies			
frequent stomach pains or vomiting			
frequent or severe headaches			
other chronic physical pains or complaints?			
wear glasses or have vision problems			
frequent ear infections			
hearing loss			
hearing aides			
Other conditions:			

Does your child have or ever had (check all that apply):

Toe walking? ڤ Loss of skills? ڤ Please explain: _____

Blank spells? ڤ Falling spells? ڤ _____

Tics or twitching? ڤ Clumsiness? ڤ _____

Is your child taking any medications on a regular basis? Y_____ N_____
If yes, please list the medications and reasons child is taking them: _____

_____

Has your child taken any other medications in the past? Y_____ N_____
If yes, please list the medications and reasons child

took them: _____

Please list the name, address, and telephone number of the primary care doctor (e.g., pediatrician, family physician) who cares for your child:

Name: _____
Address: _____
_____
_____
Telephone number: _____

VI. Social History

Has your child had angry outbursts, temper tantrums, or other behaviors that caused you concern? Describe: _____ Y_____ N_____

_____

_____

_____

How does the child respond to discipline? _____

_____

_____

Has discipline been frequently necessary? _____

_____

Who ordinarily disciplines the child? _____

Is your child's behavior different in school and at home?_____

Has your child been in trouble with the law? Please explain?_____

_____

Do you have any reason to believe your child is using or abusing drugs or alcohol? _____

_____

During the past 12 months, has your family experienced any of the following:

	Yes	***No***
Death of a family member:	_____	_____
Serious illness:	_____	_____
Unemployment:	_____	_____
Marital problems:	_____	_____
Other (please describe _____	_____	_____

Has your child ever lost any person with whom he/she seemed to have a close relationship, such as a relative, caretaker, etc.? Y_____ N_____
If yes, at what age(s)?_____
Who?_____

Have any other family members had medical problems during the past 3 years (including headaches, back pain, stomach problems, problems with nerves, asthma, diabetes). If yes, please describe: _____ Y_____ N_____

Does your child have the opportunity to play with same-age children? Y_____ N_____

Does your child prefer to play with older, younger, or same-age children? _____

Has your child ever been bullied by others? ____ has he/she bullied others?_____

Describe_____

_____

How does your child occupy himself? What toys or activities does your child seem to enjoy?

_____

_____

Has your child or family ever been seen by a psychologist, psychiatrist, or counselor? Y_____ N_____

If yes, please describe: _____

_____

_____

VII. School History

Name of School (including Early Intervention and preschool) **Location** **Years/Grades:**

1.

2.

3.

4.

Name of the child's present school _____

Contact person _____ Phone number of school _____

Current grade placement: _____

Was the child ever held back to repeat a grade? ❑ Yes ❑ No Which grade: _____

Is the child in special education? ❑ Yes ❑ No Beginning when: _____

Has your child's school and/or teacher reported current problems with: (Check)

Reading	_____	Describe:_____
Spelling	_____	Describe:_____
Writing	_____	Describe:_____
Handwriting	_____	Describe:_____
Arithmetic	_____	Describe:_____
Social adjustment	_____	Describe:_____
Attention span	_____	Describe:_____
Memory	_____	Describe:_____
Following directions	_____	Describe:_____

Has your child received any of the following services?

	Yes	*No*	*Ages or Grades*
Early Intervention	____	____	_____
Speech/language therapy	____	____	_____
Physical therapy	____	____	_____
Occupational therapy	____	____	_____
Learning disabilities tutoring	____	____	_____
Counseling	____	____	_____
Other (please describe: _____)	____	____	_____

Has your child ever been placed in any of the following designations for special educational programs?

	Yes	*No*	*Ages or Grades*
Developmental Delay	____	____	_____
Autism Spectrum Disorders	____	____	_____
Intellectual Impairment	____	____	_____
Emotional Difficulties	____	____	_____
Behavioral Difficulties	____	____	_____
Learning disabilities	____	____	_____
ADHD	____	____	_____
Hearing impaired	____	____	_____
Visually impaired	____	____	_____
Physically Challenged	____	____	_____
Health Impaired	____	____	_____
Summer Services	____	____	_____
If summer program, for what sort of services?	____ Social		____Academic

Thank you for taking the time to complete this questionnaire. I know this is a time consuming task, but the information you provide us about your child and your family helps us to fully answer your questions and allows me to be more effective in our work. Please use this space bellow or on the back of this page to share any additional pertinent information.