

Aubrey K. Ewing, Ph.D. & Associates, P.A.

1230 So. Federal Hwy, Suite 101
Boynton Beach, FL 33435
561.742-7122|Fax 561.742.7452

Childhood History Form

Child's name _____

Birth date _____ Age _____ Sex _____

Child's school: _____

Grade _____ Special placement (if any) _____

Child is presently living with:

- | | |
|--|--|
| <input type="checkbox"/> Natural Mother | <input type="checkbox"/> Natural Father |
| <input type="checkbox"/> Stepmother | <input type="checkbox"/> Stepfather |
| <input type="checkbox"/> Adoptive Mother | <input type="checkbox"/> Adoptive Father |
| <input type="checkbox"/> Foster Mother | <input type="checkbox"/> Foster Father |
| <input type="checkbox"/> Other (specify) _____ | |

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

Briefly state main problems of this child:

PARENTS

Mother:

Occupation _____

Age _____ Age at time of pregnancy with patient _____

Education: _____ Highest grade completed _____

Learning problems (describe)

Attention problems (describe)

Behavior problems (describe)

Medical problems (describe)

Has the mother or any of her blood relatives experienced problems similar to those your child is experiencing? _____

If so, describe

Father:

Occupation _____

Age _____ Age when child was born _____

Education: _____ Highest grade completed _____

Learning problems (describe)

Attention problems (describe)

Behavior problems (describe)

Medical problems (describe)

Has the father any of his blood relatives experienced problems similar to those your child is experiencing? _____

If so, describe

SIBLINGS:

Name Age Medical, social, school, mental health problems

PREGNANCY

Duration of pregnancy in weeks:

Complications:

- Excessive vomiting hospitalization required
- Excessive staining/blood loss threatened miscarriage
- Infection(s) (specify)

-
- Toxemia
 - Operation(s) (specify)

-
- Other illness (specify)

-
- Smoking during pregnancy
 - Alcoholic consumption during pregnancy
Describe if more than occasional use

-
- Medications taken during pregnancy
 - X-ray studies during pregnancy
 - Medications taken during pregnancy

DELIVERY

Duration (hours): _____

Type of labor:

- Spontaneous
- Induced

Type of delivery:

- Normal
- Breech
- Caesarean

Complications:

- Cord around neck
 - Hemorrhage
 - Infant injured during delivery
 - Other
-

POST DELIVERY PERIOD

Number of days was in the hospital after delivery: _____

- Jaundice
 - Cyanosis (turned blue)
 - Incubator care
 - Infection (specify)
-

INFANCY PERIOD

Were any of the following present to a significant degree during the first few years of life? If so, describe.

Did not enjoy cuddling

Was not calmed by being held or stroked

Difficult to comfort

Colic

Excessive restlessness

Excessively irritable

Diminished sleep

Frequent head banging

Difficulty nursing

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:

Childhood diseases (describe ages and any complication)

Operations

Hospitalizations for illness

Head injuries

Convulsions with fever without fever

Coma

Persistent high fevers

Eye problems

Ear Problems

Allergies or Asthma

Poisoning

Sleep problems

Appetite

PRESENT MEDICAL STATUS

Height: _____

Weight: _____

Present illnesses for which the child is being treated:

Medications child is taking on ongoing basis:

DEVELOPMENTAL MILESTONES

If you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall exactly, check item at right.

Milestone	Age	Early	Normal	Late
Smiled.				
Sat without support.				
Crawled.				
Stood without support.				
Walked without assistance.				
Spoke first words.				
Said phrases.				
Said sentences.				
Bladder trained, day.				
Bladder trained, night.				
Bowel trained, day.				
Bowel trained, night.				
Rode tricycle.				
Rode bicycle (without training wheels)				
Buttoned clothing.				
Tied shoelaces.				
Name colors.				
Name coins.				
Said alphabet in order.				
Began to read.				

COORDINATION

Rate your child on the following skills:

Skill or characteristic	Good	Average	Poor
Walking			
Running			
Throwing			
Catching			
Shoelace tying			
Buttoning			
Writing			
Athletic abilities			
Excessive number of accidents compared to others			

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 not?

How would you rate your child's overall level of intelligence compared to other children?

- Below average
- Average
- Above average

SCHOOL

Were you concerned about your child's ability to succeed in kindergarten? _____
If so, please explain

Rate your child's school experiences related to academic learning:

Level in school	Good	Average	Poor
Nursery school			
Kindergarten			
Current grade			

To the best of your knowledge, at what grade level is your child functioning:

- _____ Reading
- _____ Spelling
- _____ Arithmetic

Has your child ever had to repeat a grade? _____

If so, when?

Present class placement:

- regular class
- special class

If your child is in a special class or curriculum, please describe it below:

Describe any special counseling or remedial work your child is currently receiving:

Describe briefly any academic problems your child is experiencing in school:

Rate your child's school experiences related to behavior:

Level in school	Good	Average	Poor
Nursery school			
Kindergarten			
Current grade			

Does your child's teacher describe any of the following as significant classroom problems?

Behavior	Yes	No
Doesn't sit still in his or her seat.		
Frequently gets up and walks around the classroom.		
Shouts out. Doesn't wait to be called on.		
Won't wait his or her turn.		
Doesn't cooperate well in-group activities.		
Typically does better in a one to one relationship.		
Doesn't respect the rights of others.		
Doesn't pay attention during storytelling or show and tell		

Briefly describe any other classroom problems you child may have:

As best you can recall, please use the following space to provide a general description of your child's school progress in each grade.

PEER RELATIONSHIPS

Please check the boxes in front of the statements that are true about your child:

- Seeks friendships with peers
- Peers seek out my child for friendship
- My child plays with children primarily his or her own age
- My child tends to play with children younger than her/him
- My child tends to play with children older than her/him

Describe briefly any problems your child may have with peers:

HOME BEHAVIOR

All children exhibit the behaviors listed below to some degree. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her own age.

Behavior	Yes	No
Fidgets with hands, feet or squirms in seat		
Has difficulty remaining seated when required to do so		
Easily distracted by extraneous stimulations		
Has difficulty awaiting turn in games or group situations		
Blurts out answers to questions before they have been completed		
Has problems following through with instructions (Usually not due to opposition or failure to comprehend)		
Has difficulty paying attention during tasks or play activities		
Shifts from one uncompleted activity to another		
Has difficulty playing quietly		
Often talks excessively		
Interrupts or intrudes on others (Often not purposeful or planned but impulsive)		
Does not appear to listen to what is being said		
Loses things necessary for tasks or activities at home		
Boundless energy and poor judgment		
Impulsivity (Poor self control)		
Frustrates easily		
History of temper tantrums		
Temper outbursts		
Sloppy table manners		
Sudden outbursts of physical abuse of other children		
Acts like motor drives him or her		
Wears out shoes more frequently than siblings		
Excessive number of accidents		
Doesn't seem to learn from experiences		
Poor memory		
A "different child"		

Does your child create more problems, either purposeful or non-purposeful, within the home setting than his or her siblings? If yes, explain.

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 obtained other forms of information concerning discipline and behavior management?

INTERESTS AND ACCOMPLISHMENTS:

What are your child's main hobbies and interests?

What are your child's areas of greatest accomplishment?

What does your child's enjoy doing most?

What does your child's dislike doing most?
