Child's Name: _____ Birthdate _____ Sex____

Home Address: _____ City_____ State____ Zip_____

Home Telephone: _____ Mobile Phone _____

Child's School _____ Grade_____

Present placement of child (Check appropriate line)

	Adult whom child Lives with	Non-Residential Adults involved with child
Biological Mother	☐	☐
Biological Father	☐	☐
Stepmother	☐	☐
Step father	☐	☐
Adoptive Mother	☐	☐
Adoptive Father	☐	☐
Foster Mother	☐	☐
Foster Father	☐	☐
Siblings: Name and age	☐	

_____

_____

Other (specify) _____ _____

Source of referral _____

Brief Summary of the Main Problem:

_____

_____

_____

_____

PREGNANCY:

Complications:

Excessive Vomiting _____ Hospitalization Required _____

Threatened Miscarriage_____ Excessive staining or blood loss_____

Infections:_____ Toxemia_____ Operations_____

Smoking during Pregnancy_____ Average number of cigarettes a day _____

Alcohol consumption during Pregnancy _____ Average number of drinks a day_____

Medications during pregnancy_____

DELIVERY

Type of Labor: Spontaneous _____ Induced_____

Forceps: High _____ Mid _____ Low _____

Duration of labor _____ hours

Type of delivery Normal _____ Breech_____ Caesarean_____

Complications: Cord around neck_____ Cord presented first_____ Hemorrhage_____

Other:_____

Birth Weight_____ Delivery at _____Weeks Gestation

POST DELIVERY PERIOD

Respiration: Immediate _____ Delayed_____ How long_____

Cry: Immediate_____ Delayed_____ How long_____

Mucus accumulation _____ Apgar score (if known) _____

Jaundice_____ Rh Factor _____ Transfusion _____ Cyanosis (turned blue)_____

Incubator care _____ Number of days _____

Suck: Strong_____ Weak_____ Vomiting _____Diarrhea_____

Birth Defects_____ Specify_____

Total number of days baby in hospital after delivery _____

INFANCY/TODDLER PERIOD

Did not enjoy cuddling_____

Was not calmed by being held or stroked _____

Colic_____

Excessive restlessness_____

Frequent head banging_____

Constantly into everything _____

Excessive number of accidents compared to other children_____

Developmental Milestones

	Age	Early	Normal	Late	Comment
Smiled					
Sat without support					
Crawled					
Walked without support					
Spoke first words					
Bowel trained					
Bladder trained					
Buttoned Clothing					
Tied Shoes					
Rode Bike without training wheels					
Said alphabet in order					
Bladder trained day					
Bladder trained night					
Bowel trained					

Motor Skills

	Good	**Average**	**Below Average**
Walking			
Running			
Throwing			
Catching			
Writing			
Coloring/Cutting			

MEDICAL HISTORY:

Childhood Diseases (describe any complications)

_____

_____

Allergies: _____

Does parent carry Epi Pen?_____ Yes ____ No

Operations:_____

Hospitalizations: _____

Head Injuries_____

Convulsions_____ Coma _____

Meningitis or encephalitis_____

Reactions to Immunizations:_____

Persistent high Fever _____ Highest temperature recorded _____

Eye Problems_____ Ear Problems _____

Poisoning_____

Present illness for which child is being treated _____

Medications taken regularly: Name Dosage How often

_____

_____

_____

FAMILY HISTORY - MOTHER

Age_____ Age at time of pregnancy _____

Number of previous pregnancy _____ Number of Miscarriages _____

Highest grade completed _____ Learning problems _____

Behavior problems _____

Medical Problems _____

Have any of your blood relatives had issues similar to your child? _____

FAMILY HISTORY- FATHER

Age:____ Age of time at child's birth _____

Highest grade completed _____ Learning problems_____

Behavior problems _____

Medical problems _____

Have any of your blood relatives every had problems similar to those of your child's?_____

_____

ADOPTION HISTORY

Is child adopted ____Yes ____ No

Foster Family history:_____

Does child get visitation with biological family:____ Yes ____ No How often?_____

Is child related to adopted family: ____ Yes _____No

Is child aware of adoption history: _____ Yes ____No

Current case worker or social worker name: _____

Names of other professionals consulted or therapy received:

Professionals	Age	How long in therapy	Main focus of therapy	Why did therapy end
_____	___	_____	_____	_____
_____	___	_____	_____	_____
_____	___	_____	_____	_____
_____	___	_____	_____	_____

Comments:

_____
_____
_____
_____