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History Questionnaire

Child's Name:____ Today's Date: __________________

Child's Date of Birth: __________________________________Child's Age: _____ Grade in School: __________

Parent's Names: ____

Home Address: ____Zip:__________________

Telephone Numbers: (home) _____________________ (cell) ____

Email address: ____

Name of person completing questionnaire: ____

Relationship to child: ____

Who referred the child? ____

Name of School: ____ School District: ____________________

Teacher(s) Names: ____

Is your child currently designated a special education student? ______________________________________

Under what exceptionality/disability? ____

Does your child receive speech/occupational therapy? ________________ How often? __________________

Does your child go to resource room/learning support? _______________ How often? ________________

Please list any professionals that your child is working with, outside of school, that you would like me to contact (please make sure that you have completed and signed release forms for each person, and alerted them to expect my call):

Name	Specialty	Telephone number

Please list any previous diagnoses:

Diagnosis	**When was it made?**	**By whom?**

When was your child's most recent school district/Early Intervention evaluation? ________________________

Please list the major concerns that had you bring your child to be evaluated:

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Please describe your child's strengths: ____

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FAMILY HISTORY

Is your child: biological adopted foster child other

Are his/her parents: unmarried separated divorced married other

With whom does the child live? (please include all household members, including parents, siblings, grandparents, foster children, roommates): ____

____

What language (s) is/are used at home? ____

Parent 1 level of education: ____________________Parent 2: ______________________________

Parent 1 occupation: ____________________________ Parent2: ______________________________

Do any family members have a history of any of the following:

PROBLEM	FAMILY MEMBER AND RELATIONSHIP TO CHILD
Ambidextrousness	
Behavior problems	
Attention deficit disorder	
Poor school performance	
Speech articulation problems	
Language delay	
Dyslexia/reading problem	
Intellectual disability	
Epilepsy or seizures	
Genetic or chromosome disorder	
Cerebral palsy	
Autism	
Anxiety or depression	
Mental illness	

PREGNANCY AND BIRTH HISTORY:

Was this pregnancy monitored at regular intervals by a physician or midwife? ____________________________

Were there any complications during the pregnancy with your child? ____

____

How were they treated? ____

Did biological mother smoke cigarettes? _________Drink alcohol? ____________ Use drugs?________________

____

Length of pregnancy _________________Apgar scores (if known) _________Birthweight________________________

Was labor: spontaneous induced Reason if induced: ____

Was delivery: vaginal C-section Reason if C-section: ______________________________

Did the child require: forceps vacuum extraction resuscitation at birth?

Did the child experience any of the following? Rh incompatibility jaundice

Were there any other complications at delivery, birth, or in the newborn period? ______________

____

____

Child's Medical History:

Has your child ever had any of the following (please describe, including dates, diagnostic studies, and treatments to date)

Seizures/convulsions (type, frequency, duration) ______________________________

Meningitis or encephalitis? ______________________________

Surgery ______________________________

Hospitalizations ______________________________

Head injuries ______________________________

Allergies ______________________________

Frequent ear infections ______________________________

Placement of PE tubes in ears? ______________________________

List the child's medications and daily dosages: ______________________________

When was your child's vision last tested? ______________ By whom? ______________

Results: ______________ Does your child wear eyeglasses? ______________

When was your child's hearing last tested? ________ By whom? ______________

Results: ______________ Does your child wear a hearing aid? ______________

When was your child's last visit to the pediatrician? ______________________________

Child's Developmental History:

Describe your child's temperament in infancy:______________________________

Was s/he easily soothed? ______________________________

Did s/he respond to cuddling? ______________________________

At what age did your child say first word? ____________ Two words together? ____________

Speak in sentences? ____________ When was s/he first easily understood by strangers?

____

Was your child's understanding of language similar to others his/her age?______________

When did your child first sit by him/herself? ______________________________

Crawl? ________ Stand? ________ Walk? ________ Run? ________

Does your child show a hand preference? ____For which hand? _______ When did this begin? ________

Was your child's development delayed in any way? In what way? ______________________________

____

When did you first become concerned? ______________________________

Did you consult a professional? Who was it? ______________________________

What was recommended? ____

Was the child evaluated (please give details: at what age, by whom, results/recommendations)? ____

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Did your child receive Early Intervention services as an infant/toddler? _____________________

Why was your child considered eligible for services? ____________________________________

____

Please list types of therapies, start and end dates, and weekly frequencies: ___________________

____

Preschool History: Please describe the type of preschool your child attended and any outstanding areas of strength or difficulty s/he encountered:

Preschool	Dates attended	Strengths/issues	Teachers name

School History:

Please list the elementary school(s) your child has attended, with beginning and ending dates:

School	Dates attended	Strengths/issues	Teachers name

Describe your child's adjustment to kindergarten (with behavioral, social, and academic expectations)

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____

Did your child have difficulty with learning the alphabet and with early reading? _______________

____

Math? ____

Did s/he receive any extra help? ________ What kind? _________________________________

When did you first notice a problem? ____

Describe the problems noted then: ____

Have there been any difficulties with adjustment/behavior/academic expectations/social interaction at school (please describe):

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Has your child's teacher noted any difficulties that you have not described above? _______________

____

What is your plan for your child's next school year (or what options are you considering)? _______

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Describe your child's strengths at school: ____

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Current Functioning at Home:

Do you have any concerns about your child's behavior at home? Please describe them: ________

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Have you sought the assistance of a psychologist/ therapist/ counselor to help with behavior? _____

If so, who was it? Describe frequency/ duration. Was it helpful? ____________________________

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How is your child disciplined? ________________ How well does it work? ________________

Any concerns about your child's eating habits? ____

Sleeping habits? ____

Describe your child's usual play choices: ____

____

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____

Does your child play with other children in the neighborhood? ______________________

Have play dates with friends from school? ________________________________

Is there any current, unusual marital/family/family health stress that might be affecting your child?

____

Previous Evaluations

Has your child had any of the following evaluations? Please list dates, names of professionals, and test results:

Evaluation	Date	Results
Speech/Language		
Occupational Therapy		
Physical Therapy		
Developmental Evaluation		
Psychological Evaluation		
Neuropsychological Evaluation		
School Testing		
CT scan		
MRI scan		
EEG		
Neurological Evaluation		

Comments:

Please add any helpful comments, information, or concerns that you have not listed above. __________

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Thank you.