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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:

_____

_____

_____

_____

_____

_____

Please describe your child's strengths: _____

_____

_____

_____

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)? ____

_____

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)

_____

_____

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):

_____

_____

_____

_____

_____

_____

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)? _____

_____

Describe your child's strengths at school: _____

_____

_____

_____

_____

Current Functioning at Home:

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

_____

_____

_____

_____

_____

_____

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? _____

_____

_____

_____

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: _____

_____

_____

_____

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. _____

_____

_____

_____

_____

_____

_____

Thank you.