Integrative Therapy of Greater Washington
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# CHILDHOOD HISTORY FORM

Child's Full Name ______________________________________________________________________

Date of Birth _________________________ Age __________ Sex M F SS # __________________

Home Address __________________________________________________________________________
Street Apt. # City State

Home Phone _____________________ Grade _________________ Name of School __________________

**SCHOOL HISTORY**

Special Placement in School (if any) ___________________________________________________________

List all schools attended and length of attendance, current and past _______________________________________

______________________________________________________________________________________

Has your child repeated any grades? Y / N If yes, what grade(s)?

Rate academic performance: (circle) Good Average Poor

**FAMILY STATUS**

Are the child's parents (please circle) married never married separated divorced Age of child at divorce _______________

Was your child adopted? N Y if yes, at what age _______How long did s/he live with you before adoption was final? ______

With whom does the child presently live? (please circle) Natural Mother Natural Father Stepmother St

Adoptive Mother Adoptive Father Foster Mother Foster Father Grandmother Gr

Legal Guardian _______________________________________________________________________________

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

Has Child Protective Services (OCS/DCFS) been involved in your family? N Y *If yes, provide explanation on back page*.

**SIBLINGS** Name Age Medical, Social, Emotional, or School Problems

1. ______________________________________________________________________________________
2. ______________________________________________________________________________________
3. ______________________________________________________________________________________
4. ______________________________________________________________________________________
5. ______________________________________________________________________________________
6. ______________________________________________________________________________________

Have there been any family changes or stressors, such as relocation, separation, etc.? N Y if yes, please describe: ___________

## PREGNANCY

Duration of Pregnancy: Full Term? Y N If born premature, list number of weeks ___________________

Complications? N Y If yes, describe (i.e. substance use, maternal health, etc.):_____________________________________

______________________________________________________________________________________________

## DELIVERY

Birth Weight ________________________________

Type of labor: Spontaneous _____ Induced _____ Duration (hrs.) ______

Type of Delivery Normal _____ Induced _____ Caesarean _____

Complications: Cord around neck N Y Hemorrhage N Y Injury during delivery N Y specify ______________________

## POST-DELIVERY PERIOD

Jaundice N Y Cyanosis (turned blue) N Y Infections N Y specify ___________________________________________

Incubator care N Y # of days infant was in hospital after delivery _________ NICU care N Y

## DEVELOPMENTAL MILESTONES

If you can recall any, record the age at which your child reached the following milestones. If you cannot recall any, check one *Ear Late*

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

Received Early Intervention Services (i.e. Infants and Toddlers)? N Y

## MEDICAL HISTORY

Pediatrician/Primary Care Physician ______________________________________________________________

Name Address Phone Number

Any current/past medical conditions? N Y If child is healthy, skip to next section.

List all current/past medical conditions (i.e. hospitalizations, head injuries, asthma, etc.):

______________________________________________________________________________________________

______________________________________________________________________________________________

Occupational/Physical/Speech Therapies? N Y Date and Provider ____________________________________________
____________________________________________________________________________________________

**BEHAVIORAL HEALTH HISTORY**

Has the family or child participated in counseling/ therapy? N Y Date and Provider ______________________________
Has your child received a psychological evaluation before? N Y Date and Provider ______________________________
Has your child received a psychiatric evaluation before? N Y Date and Provider ________________________________

**LIST THE NAMES AND ADDRESSES OF OTHER PROFESSIONALS CONSULTED**

1. ______________________________________________________________________________________
2. ______________________________________________________________________________________
3. ______________________________________________________________________________________
4. ______________________________________________________________________________________
5. ______________________________________________________________________________________

## FAMILY HISTORY

**MOTHER**

Name ______________________________________________________________________________________
Date of birth ______________________________ Age at time of pregnancy with child ____________________
Occupation ________________________________ Highest Grade Completed ___________________________
Is there a history of: (if so, explain)
Learning Problems N Y _____________________________________________________________________
Attention Problems N Y _____________________________________________________________________
Behavioral Problems N Y ____________________________________________________________________
Emotional and/or Psychiatric Problems N Y _____________________________________________________
Prescriptions used (past & present) for these problems:___________________________________________
Medical Problems N Y ______________________________________________________________________
Describe any behavioral, emotional, or psychiatric problems of blood relatives ____________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

**FATHER**

Name ______________________________________________________________________________________
Date of birth ______________________________ Age at time of child's birth ___________________________
Occupation ________________________________ Highest Grade Completed ___________________________
Is there a history of: (if so, explain)
Learning Problems N Y _____________________________________________________________________
Attention Problems N Y _____________________________________________________________________
Behavioral Problems N Y ____________________________________________________________________
Emotional and/or Psychiatric Problems N Y _____________________________________________________
Prescriptions used (past & present) for these problems:___________________________________________
Medical Problems N Y ______________________________________________________________________
Describe any behavioral, emotional, or psychiatric problems of blood relatives ____________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

**INTERESTS AND ACCOMPLISHMENTS**

What are your child's extracurricular activities? _________________________________________________
What does your child most enjoy doing? _______________________________________________________

What does your child most dislike doing? ______________________________________________

List your child's areas of strength ______________________________________________

**ADDITIONAL COMMENTS**

Please use space below as needed.