

Psychological Services of Pendleton, LLC

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CHILDHOOD HISTORY FORM

Name of child _____ SSN: _____

DOB _____ Age _____ Male Female

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Referred by _____

School _____

Grade in school _____ Special placement (if any): _____

School address _____

School phone _____ Teacher _____

Describe your child's problems(s) in order of difficulty

1. _____
2. _____
3. _____
4. _____
5. _____

How are the above problems impacting your child's life?

1. _____
2. _____
3. _____
4. _____
5. _____

How are the problems impacting the family's life?

1. _____
2. _____
3. _____
4. _____
5. _____

FAMILY INFORMATION:

Mother and/or Stepmother's name _____ DOB _____

Mother and/or Stepmother's employer _____

Address _____

Phone _____ Length of employment _____

Year married (if applicable) _____ # Years together with Spouse/S.O. _____

Mother and/or Stepmother's education:

Highest grade completed _____ Date _____

Learning problems _____

Attention problems _____

Behavior problems _____

Medical problems _____

Have any of the mother's blood relatives experienced problems similar to those your child is experiencing? If so, describe:

Father and/or Stepfather's name _____ DOB _____
Father and/or Stepfather's employer _____
Address _____
Phone _____ Length of employment _____
Year married (if applicable) _____ # Years together with Spouse/S.O. _____

Father and/or Stepfather's education:
Highest grade completed _____ Date _____
Learning problems _____
Attention problems _____
Behavior problems _____
Medical problems _____

Have any of the father's blood relatives experienced problems similar to those your child is experiencing? If so, describe:

FAMILY HOUSEHOLD MEMBERS:

Name _____	DOB _____	Age _____	Relationship to Child _____
Name _____	DOB _____	Age _____	Relationship to Child _____
Name _____	DOB _____	Age _____	Relationship to Child _____
Name _____	DOB _____	Age _____	Relationship to Child _____
Name _____	DOB _____	Age _____	Relationship to Child _____

STEPFAMILY MEMBERS (if applicable):

Name _____	DOB _____	Age _____	Relationship to Child _____
Name _____	DOB _____	Age _____	Relationship to Child _____
Name _____	DOB _____	Age _____	Relationship to Child _____
Name _____	DOB _____	Age _____	Relationship to Child _____

Child is presently living with:

_____ Natural mother	_____ Natural father	_____ Stepmother
_____ Adoptive mother	_____ Adoptive father	_____ Stepfather
_____ Foster mother	_____ Foster father	_____ Other (specify) _____

How many times have you moved since the child's birth? _____

If more than once, why? _____

What is your family's religion? _____

Does the family attend church regularly? _____

If the biological parents have **divorced/separated/or otherwise not together** – describe the *emotional* environment of the household the child resided in and how the child reacted emotionally and behaviorally to the situation AT THAT TIME:

If the biological parents have **divorced/separated/or otherwise not together** – describe your perception of the *emotional* environment of the non-custodial parent's household when the child is visiting and how the child reacts emotionally and behaviorally while at the non-custodial parent's home:

PREGNANCY & DELIVERY

Mother’s age at the time of pregnancy with child _____
 Was there anything you or your doctor considered unusual during pregnancy? _____
 Smoking before/during pregnancy _____ / _____ # of cigarettes per day _____ / _____
 Alcoholic consumption before/during pregnancy _____ / _____
 Describe if beyond an occasional drink _____
 Medications taken during pregnancy _____
 Type of delivery: Normal _____ Breech _____ C-section _____
 Birth weight _____ APGAR scores (if known) _____
 Complications:
 Cord around neck _____ hemorrhage _____
 Other _____
 Jaundice _____ cyanosis (turned blue) _____
 Infection (specify) _____
 Number of days infant was in the hospital after delivery _____
 Breastfed? _____ How long? _____ Formula Allergies? _____

DEVELOPMENTAL MILESTONES

What is your child’s hand preference? _____ R _____ L _____
 AGE EARLY NORMAL LATE
 Crawled _____
 Walked without assistance _____
 Spoke first words _____
 Said sentences _____
 Bladder trained, day _____
 Bowel trained, day _____
 Buttoned clothing _____
 Tied shoelaces _____
 Began to read _____

Was there anything, in the first three years, which you thought might affect future growth, development or school success?

CHILD CARE HISTORY

Mother employed outside the home when child was younger? _____ Hours per week _____
 Work day hours _____
 How much time per day did you spend with your child when he or she was younger? _____
 Father employed outside the home? _____ Hours per week _____ Work day hours _____
 How much time per day did you (father) spend with your child when he or she was younger? _____
 Who took/takes care of your child while parents are working? _____

DEVELOPMENTAL COORDINATION

Rate your child on the following skills when he/she was younger *compared to other children his/her age*:
 GOOD AVERAGE POOR
 Walking _____
 Running _____
 Throwing _____
 Catching _____
 Shoelace tying _____
 Buttoning _____
 Writing _____
 Athletic abilities _____

Does your child appear to have an *excessive* number of accidents *compared to other children his/her age*?

Please check any of the following that concern you about your child:

- | | |
|--|--|
| <input type="checkbox"/> Disobedience | <input type="checkbox"/> Lack of friends |
| <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Unacceptable friends |
| <input type="checkbox"/> Moodiness | <input type="checkbox"/> Clumsiness |
| <input type="checkbox"/> Arguing | <input type="checkbox"/> Disorganization |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Low self-esteem |
| <input type="checkbox"/> Lying | <input type="checkbox"/> Frequent crying |
| <input type="checkbox"/> Stealing | <input type="checkbox"/> Gives up easily |
| <input type="checkbox"/> Drug use | <input type="checkbox"/> Verbal fighting |
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Hitting |
| <input type="checkbox"/> Tobacco use | <input type="checkbox"/> Whining |
| <input type="checkbox"/> Sexual behavior | <input type="checkbox"/> Head or stomach aches |
| <input type="checkbox"/> Overly active | |
| <input type="checkbox"/> Other _____ | |

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations *compared to other children his/her age?* If not, why not?

How would you rate your child's overall level of intelligence *compared to other children his/her age?*

Below average _____ Above average _____ Average _____

MEDICAL HISTORY

Child's Physician _____ Phone _____

Address _____

Medications currently prescribed for your child _____

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 (type, age, and any subsequent complications) _____

Operations _____

Hospitalizations for:

Illness _____

Head injuries _____ Loss of Consciousness _____

Convulsions _____ with fever _____ without _____

Seizures _____

Coma _____

Persistent high fevers _____

Eye problems _____

Ear problems _____

Allergies or asthma _____

Poisoning _____

Sleep problems _____

Appetite _____

Has your child ever been treated for a psychological/behavioral problem? _____

By whom? _____

When? _____ What for? _____

Where: In hospital _____

Outpatient _____

Kind of treatment: _____ Individual _____ Family _____ Medication _____

With whom? _____

FAMILY HISTORY (Family is defined as: brothers, sisters, parents, grandparents, aunts, uncles, and cousins).

Do you have any family members with the following problems (problems can be subclinical)?

Condition Relation (ex. maternal grandmother, paternal uncle)

Learning problems _____
Attention problems/hyperactivity _____
Impulse control problems _____
Alcoholism/drug addiction _____
Epilepsy _____
Mental retardation _____
Trouble with the law _____
Depression _____
Anxious or overly perfectionistic _____
Problems with speech or hearing _____
Schizophrenia or Bipolar Disorder _____
Psychiatric hospitalization _____
Other behavioral or emotional problems _____

SCHOOL HISTORY

Please list all the schools your child has attended:

SCHOOL	CITY/STATE	GRADE
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child had any difficulty in school? Please describe specifically: _____

Has any special testing been completed? _____

When? _____ Results (*attach copy of report*)? _____

Has your child been seen by a school counselor? _____

What for? _____

As a rule, does/did your child complete and hand in homework? _____

How much time does your child spend doing homework each day? _____

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

	GOOD	AVERAGE	POOR
Nursery school	_____	_____	_____
Kindergarten	_____	_____	_____
Grade school	_____	_____	_____
Middle school	_____	_____	_____
Current	_____	_____	_____

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

Reading _____ Spelling _____ Arithmetic _____ Science _____

Has your child ever had to repeat a grade? If so, when? _____

Present class placement: Regular class _____ Special class (if so, specify) _____

Kinds of special counseling or remedial work your child is currently receiving _____

Rate your child's school experiences related to ***behavior***:

	GOOD	AVERAGE	POOR
Nursery school	_____	_____	_____
Kindergarten	_____	_____	_____
Grade school	_____	_____	_____
Middle school	_____	_____	_____
Current	_____	_____	_____

Does/did your child's teacher complain about any of the following as significant *classroom* problems (mark X)?

- 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 _____
- Describe briefly any other classroom behavior problems _____
- _____
- _____
- _____

BEHAVIORAL HISTORY

Has the child ever: (please check all that apply)

- _____ Been physically abused
- _____ Been emotionally abused
- _____ Been sexually abused? By whom: _____ For how long/how many times _____
- _____ Treated for above abuse? _____
- _____ Arrested or adjudicated? For what? _____
- _____ Result _____
- _____ Stolen What? _____
- _____ From whom? _____
- _____ Run away from home
- _____ When? _____ For how long? _____
- _____ Set fire When? _____
- _____ Has a quick temper
- _____ Assaulted someone
- _____ Who? _____ What happened? _____
- _____ _____
- _____ _____
- _____ Destroyed property When? _____ How? _____
- _____ Hurt self When? _____ How? _____
- _____ Threatened to hurt self When? _____ How? _____
- _____ Threatened to hurt someone else When? _____
- _____ Who? _____ How? _____
- _____ Used a weapon When? _____ What? _____
- _____ Used alcohol When? _____ What? _____
- _____ Used drugs When? _____ What? _____
- _____ Used tobacco When? _____
- _____ Been sexually active At what age? _____
- _____ Been a gang member
- _____ Been cruel to animals

HOME BEHAVIOR

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

- _____ Fidgets with hands, feet or squirms in seat
- _____ Has difficulty remaining seated when required to do so
- _____ Easily distracted by extraneous stimulation
- _____ Has difficulty waiting his or her turn in games or in group situations
- _____ Interrupts or intrudes on others [impulsively (X) _____, or on purpose (X) _____]
- _____ Blurts out answers to questions before they have been completed
- _____ Has problems following through with instructions (not due to opposition/defiance)
- _____ Does not appear to listen to what is being said
- _____ Fails to comprehend verbal or written instructions
- _____ Shifts from one uncompleted activity to another
- _____ Has difficulty playing quietly
- _____ Often talks excessively

- _____ Loses things necessary for tasks or activities
- _____ Boundless energy
- _____ Poor judgment
- _____ Impulsivity (poor self-control)
- _____ Frustrates easily
- _____ Temper outbursts
- _____ Sloppy table manners
- _____ Acts like he or she is driven by a motor
- _____ Wears out shoes more frequently than siblings
- _____ Excessive number of accidents
- _____ Doesn't seem to learn from experiences
- _____ Poor memory
- _____ A "difficult child"

Does your child create more problems, either on purpose or impulsively, within the home setting than his or her siblings? _____

Explain: _____

Types of discipline you use(d) with your child _____

Is there a particular form of discipline that has proven effective? _____

Parent or Guardian Signature: _____ Date: _____