

**CONFIDENTIAL PERSONAL HISTORY
FOR CHILDREN AND YOUNG ADULTS**

Today's Date: _____ Completed by: _____

Last Name: _____ Child's Name: _____

Address: _____ Birthdate: _____ Age: _____

City, State, Zip: _____ Gender: _____

_____ Ethnicity: _____

CONTACT INFORMATION

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

Home phone: _____ Home phone: _____

Cell phone: _____ Cell phone: _____

Emergency: _____

Name	Relationship	Phone
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School: _____ Grade in School: _____

Teacher's Name: _____ Type of Classroom: _____

Child's Physician's or Health Care Providers (including Primary Care Physician):

Name: _____ Profession: Phone: _____

Address: _____

Name: _____ Profession: Phone: _____

Address: _____

Name: _____ Profession: Phone: _____

Address: _____

Date of Child's Last Medical Checkup: _____ Height: _____ Weight: _____

Are there any medical precautions the therapist should be aware of when working with your child?

FAMILY MEMBERS – Detailed Information

	Age	Sex	Adopted		Occupation	Handedness	
Father	_____	___	Yes	No	_____	R	L
Stepfather	_____	___	Yes	No	_____	R	L
Mother	_____	___	Yes	No	_____	R	L
Stepmother	_____	___	Yes	No	_____	R	L
Children	_____	___	Yes	No	_____	R	L
	_____	___	Yes	No	_____	R	L
	_____	___	Yes	No	_____	R	L

Marital Status of Parents: ___ Married ___ Separated ___ Divorced ___ Other

Mother's Education ___ Less than High School ___ High School or GED ___ College ___ Post College (grad school)
Stepmother's Education ___ Less than High School ___ High School or GED ___ College ___ Post College (grad school)

Father's Education ___ Less than High School ___ High School or GED ___ College ___ Post College (grad school)
Stepfather's Education ___ Less than High School ___ High School or GED ___ College ___ Post College (grad school)

PERSONALITY PROFILE

What are your child's gifts / strengths? _____

What do you enjoy most about your child and family? _____

What are the presenting problems for your child? (All categories below may not apply.)

Academic: _____

Activities of daily life (e.g. eating, dressing): _____

Relationships: _____

Sensory: _____

Motor: _____

Play: _____

Other: _____

What kind of interests and activities does your child have? (hobbies, sports, clubs)

Please list them in order of preference beginning with the favorite activity.

Has your child been diagnosed with (PLEASE CHECK ALL THAT APPLY):

ADD

ADHD

Anxiety Disorder or Mood Disorder (specify): _____

Autistic Spectrum Disorder

Cognitive Delay

Down Syndrome

Dyslexia

Emotional Disorder (specify): _____

Fragile X Syndrome

Learning Disabilities (specify if possible): _____

Sensory Processing Disorder or Sensory Integration Dysfunction

Tourette's Syndrome

Other (specify): _____

Please note, who provided the diagnosis and based on what criteria (i.e., test scores,

comprehensive clinical evaluation, genetic study, etc.): _____

MEDICATIONS

List any medications your child has received **in the past**:

Medication: _____ Purpose: _____ When taken: _____
Medication: _____ Purpose: _____ When taken: _____
Medication: _____ Purpose: _____ When taken: _____
Medication: _____ Purpose: _____ When taken: _____
Medication: _____ Purpose: _____ When taken: _____

List any medications your child is **currently** taking, its purpose and frequency of dosage:

Medication: _____ Purpose: _____ When taken: _____
Medication: _____ Purpose: _____ When taken: _____
Medication: _____ Purpose: _____ When taken: _____
Medication: _____ Purpose: _____ When taken: _____
Medication: _____ Purpose: _____ When taken: _____

FAMILY ADAPTATION

How would you describe your child's general adjustment at home? Poor Fair Good Excellent

How does your child get along with each member of the family?

Father _____

Mother _____

Siblings _____

Have there been any traumatic family events in the course of this child's development?

Have there been any major moves? (city to city, country to country)

PREGNANCY (If child is adopted, skip to Adoption Section)

What kind of experience was the pregnancy for both mother and father?

Mother _____

Father _____

(continued on next page)

	Yes	No	Comments
Was it planned?	_____	_____	_____
Were there complications?	_____	_____	_____
shock	_____	_____	_____
severe stress	_____	_____	_____
loss of a loved one	_____	_____	_____
accident	_____	_____	_____
health problems, specify	_____	_____	_____
confinement to bed	_____	_____	_____
other	_____	_____	_____
Was the mother exposed to loud noises?	_____	_____	_____
Did mother smoke?	_____	_____	_____
Did mother consume alcohol?	_____	_____	_____
Did mother take any medication? specify	_____	_____	_____
Was mother physically active?	_____	_____	_____
Were any previous pregnancies complicated?	_____	_____	_____

LABOR AND DELIVERY

Describe your experience during labor and delivery _____

		Comments
Length of labor?	_____ Hrs	_____
Premature: specify	Yes _____ No _____	_____
Forceps used	Yes _____ No _____	_____
High forceps required	Yes _____ No _____	_____
Suction	Yes _____ No _____	_____
Delivery position (ex: breech)	_____	_____
Caesarean birth (reason)	Yes _____ No _____	_____
Birth weight	_____ lbs _____ oz	_____
APGAR ratings (if known)	_____ _____	_____
Cried immediately	Yes _____ No _____	_____
Required special treatment (i.e. required oxygen, had jaundice, etc.)	Yes _____ No _____	_____

Birth injuries: specify Yes _____ No _____ _____

Did the newborn have immediate physical contact with the mother? Yes _____ No _____ _____

Was there a positive bonding experience between mother and newborn at birth? Yes _____ No _____ _____

Describe and separations from mother during first days of life _____

Did mother experience any post-partum depression? Yes _____ No _____ _____

ADOPTION

Describe the circumstances surrounding the adoption.

More specifically:

Age when adopted: _____

Prior foster homes: _____

Physical appearance: _____

Response to new home: _____

Is your child aware of his/her adoption? _____

INFANT & TODDLERHOOD

Going back to the **first two years** of the child's life, what type of baby was he/she? (feeding, sleeping, activity level)

(continued on next page)

	Yes	No	Comments
Breastfed	_____	_____	_____
Extended separation during first two years (over 3 days)	_____	_____	_____
Specific health problems during this period	_____	_____	_____
Thumb sucking / pacifier (until what age)	_____	_____	_____
Feeding problems	_____	_____	_____
Sleeping problems	_____	_____	_____
Colic or "fussy baby"	_____	_____	_____
Prefer certain positions as an infant (describe)	_____	_____	_____
Dislike lying on stomach	_____	_____	_____
Dislike lying on back	_____	_____	_____
Able to self soothe	_____	_____	_____
On a regular schedule	_____	_____	_____
Enjoy bouncing	_____	_____	_____
Become calmed by car rides or infant swings	_____	_____	_____
Become nauseated by car rides or infant swings	_____	_____	_____
Crawled (at what age)	_____	_____	_____
Tow walker (until what age)	_____	_____	_____
Go through "terrible twos"	_____	_____	_____
Describe your child's toddler stage:	_____		

CHILDHOOD ILLNESS / PROBLEMS

	Age	Comments / Deficits
_____ Ear infections	_____	_____
_____ Tubes in ears	_____	_____
_____ Respiratory problems	_____	_____
_____ High fever	_____	_____
_____ Meningitis	_____	_____
_____ Adenoid problems	_____	_____
_____ Frequent colds	_____	_____
_____ Strep throat	_____	_____
_____ Allergies	_____	If yes, please specify: _____

Check the items below which have been a problem and provide details:

Asthma	_____	_____
Bronchitis	_____	_____
Skin problems	_____	_____
Gastro-Intestinal problems	_____	_____
Seizures	_____	_____
Epilepsy	_____	_____
Nightmares	_____	_____
Sleep	_____	_____
Bedwetting	_____	_____
Nail Biting	_____	_____
Broken limbs	_____	_____
Other	_____	_____

Has he/she ever been hospitalized? Yes ___ No ___
If yes, list reasons: _____

Has he/she ever had a serious accident/injury? Yes ___ No ___
If yes, list accidents: _____

Are there any other medical illnesses or conditions which have been diagnosed?

Is your child in good general health at the present time? _____

DEVELOPMENTAL MILESTONES

(Give approximate ages if remembered, or comment on anything unusual)

Rolling over _____ Walk _____ Say words _____
Sit alone _____ Chew solid food _____ Say sentences _____
Crawl _____ Drink from a cup _____

Was crawling phase brief? Yes ___ No ___ Absent? Yes ___ No ___

Did child use a walker (rolling plastic seat)? Yes ___ No ___ If yes, how often? _____

Experience hesitancy or delays in learning to go down stairs? Yes ___ No ___

VISUAL DEVELOPMENT

Has your child experienced any problems with his/her eyesight or vision? _____

Are there any current problems of which you are aware? _____

When was the last time his/her eyesight was tested? _____

AUDITORY DEVELOPMENT

Has your child experienced any problems with his/her hearing? (operations, infections, tubes)

Ear infections? Seldom ___ Sometimes ___ Often ___
 Mild ___ Moderate ___ Severe ___

Are there any current hearing problems of which you are aware?

SPEECH AND LANGUAGE DEVELOPMENT

How would you describe your child's speech and language development?

Normal ___ Delayed ___ Advanced ___

Did your child begin speaking single words, then two, then a sentence? Yes No

Did your child not talk for a long while, then all of a sudden speak in complete sentences? Yes No

Do you or others have difficulty understanding what child says? Yes No

First words and at what age: _____

Describe any speech related problems: _____

SENSORY and MOTOR DEVELOPMENT

Please check any that apply:

_____ My child seems to be overly sensitive to sensory experiences more so than most people:

___Auditory ___Tactile ___Visual ___Movement ___Taste ___Smell

_____ My child doesn't seem to react to sensory experiences as readily as most people:

___Auditory ___Tactile ___Visual ___Movement ___Taste ___Smell

- My child actively seeks out sensory experiences more so than most people:
 Auditory Tactile Visual Movement Taste Smell
- My child has difficulty differentiating sensory experiences.
(ex: confuse sounds, can't find objects in drawer or bag without looking, bumps into things)

Describe: _____

- My child has trouble learning new movements.
 My child tends to be clumsy and has balance and coordination problems.

ACTIVITIES OF DAILY LIVING

EATING

Does your child finger feed? Yes No Comments: _____

Does your child use:
 Fork Spoon Sippy Cup Regular Cup Other: _____

DRESSING

Does your child assist with dressing? Yes No Comments: _____

Does your child put on/ take off:
 Socks Shoes Pants/Shorts Shirts Coats

Does your child manipulate fasteners:
 Zippers Snaps Velcro Buttons

TOILETING

Is your child potty trained? Yes No Comments: _____

Is your child able to manage clothes for toileting? Yes No Comments: _____

Is your child able to wash their hands independently after toileting? Yes No Comments: _____

PREVIOUS TESTING AND TREATMENTS

Has your child had any previous ASSESSMENTS or TREATMENT
Please attach relevant reports

	ASSESSMENTS			TREATMENTS		
	Yes	No	Place / Date	Yes	No	Place / Date
Medical	_____	_____	_____	_____	_____	_____
Audiological	_____	_____	_____	_____	_____	_____
Speech	_____	_____	_____	_____	_____	_____
Educational	_____	_____	_____	_____	_____	_____
Psychological	_____	_____	_____	_____	_____	_____
Occ. Therapy	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____

Comments: _____

Have there been any specific events or traumas linked with the onset of your child's difficulties?

Is your marital situation stable and positive at this time? _____

What, if any, stresses are affecting your family at this time?

Which language(s) is spoken at home? _____

Are there other individuals or family members living at home? (other than immediate family)

EDUCATION

How did your child adapt to the first day(s) at school or pre-school:

Mostly positive ____ Mixed ____ Mostly negative ____

How old was he/she? ____ How much time did he/she attend per week? ____

In general, how would you describe your child's experience/learning at school from kindergarten to the present time?

(continued on next page)

Please give us more detailed information about any difficulties your child encountered in school beginning with the earliest experience:

Initial school adjustment _____

Pre-school/Daycare _____

Primary (K – Gr. 3) _____

Junior (Gr. 4-6) _____

Intermediate (Gr. 7-8) _____

High School _____

Has there been remedial help given **inside** the school system? Yes ___ No ___

If yes, describe: _____

GOALS

What are your goals for your child's program? Please be specific as possible.

1. _____

2. _____

3. _____

4. _____

5. _____

How did you hear about Pediatric Therapy Partners Clinic? _____
