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

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)

Fathers'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 y our 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? _____

_____