Confidential Personal History – Child/Youth

Today's Date: ______________________ Completed by: ______________________

Last Name: ______________________ **First Name:** ______________________

Address: ______________________ Birthdate: __________ Age: __________

City, State, Zip: ______________________ Gender: ______________________

______________________ Ethnicity: ______________________

Parent A's Name: ______________________ **Parent B's Name:** ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Home Phone: ______________________ Home Phone: ______________________

Cell Phone: ______________________ Cell Phone: ______________________

Email: ______________________ Email: ______________________

Other Emergency Contact: ____________________________________

School: ______________________ **Grade in School:** ______________________

Teacher's Name: ______________________ Type of Classroom: ______________________

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

Name: ______________________ Profession: ______________ Phone: ______________

Address: ____________________________________

Name: ______________________ Profession: ______________ Phone: ______________

Address: ____________________________________

Name: ______________________ Profession: ______________ Phone: ______________

Address: ____________________________________

Date of Child's Last Medical Checkup: ______________ Weight: __________ Height: __________

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

____

____

FAMILY MEMBERS – DETAILED INFORMATION

	Name	Age	Sex	Adopted	Occupation	Handedness
Father	____________	______	________	Yes No	____________	L R
Stepfather	____________	______	________	Yes No	____________	L R
Mother	____________	______	________	Yes No	____________	L R
Stepmother	____________	______	________	Yes No	____________	L R
Children	____________	______	________	Yes No	____________	L R
	____________	______	________	Yes No	____________	L R
	____________	______	________	Yes No	____________	L R

Marital Status of Parents: ____Married ____Separated ____Divorced ____Other

Mother's Education
____ Less than High School
____ High School or GED
____ College
____ Grad School

Stepmother's Education
____ Less than High School
____ High School or GED
____ College
____ Grad School

Father's Education
____ Less than High School
____ High School or GED
____ College
____ Grad School

Stepfather's Education
____ Less than High School
____ High School or GED
____ College
____ Grad School

PERSONALITY PROFILE

What are your child's gifts/strengths? ____

____

____

____

What do you enjoy most about your child/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 (e.g. 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 (e.g. 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 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?

Parent A __________________________________

Parent B __________________________________

	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 mother exposed to loud noises?			
Did mother smoke?			
Did mother consume alcohol?			
Did mother take any medication?			Specify:
Did mother talk much?			
Was mother physically active?			
Were any previous pregnancies complicated?			

LABOR & 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	Yes ____ No ____	

oxygen, had jaundice, etc.)
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 any 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?________________

INFANCY & TODDLERHOOD

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

____

____

____

____

	Yes	No	Comments
Breastfed			
Extended separations 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)	___	___	___
Toe walker (until what age)	___	___	___
Go through "terrible twos"	___	___	___

Describe your child's toddler stage: ___

___

CHILDHOOD ILLNESSES / PROBLEMS

		Age	Comments / Deficits
___	Ear infections	___	None / A Couple / Many ___
___	Tubes in ears	___	___
___	Respiratory problems	___	___
___	High fever	___	___
___	Meningitis	___	___
___	Adenoid problems	___	___
___	Frequent colds	___	___
___	Strep throat	___	___
___	Allergies (specify)	___	___

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

		Comments / Deficits
Asthma	___	___
Bronchitis	___	___
Skin problems	___	___
Gastro-Intestinal problems	___	___
Seizures	___	___
Epilepsy	___	___
Nightmares	___	___
Sleep	___	___
Bedwetting	___	___
Nail biting	___	___
Broken limbs	___	___
Other	___	___

Has she/he ever been hospitalized? Yes___ No___

If yes, list reasons: ___

Has she/he 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 experiences 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 in 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 your 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.

PREVIOUS TESTING AND TREATMENTS

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

	ASSESSMENTS			TREATMENT		
	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? ____

____

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) ____

____

____

Highschool (Gr. 9-12) ____

____

____

Has there been any remedial help given **inside** the school system? Yes______ No______

If yes, describe: ____

____

____

____

GOALS

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

1.____

____

____

2.____

____

____

3.____

____

____

4.____

____

____

5.____

____

____

How did you hear about *I Can Therapy*?____________________________

If you were referred:

Referred by: ________________________ Profession: ________________________

Address:____

Optional: *I Can Therapy* has my permission to send a thank you letter to my referral source indicating that my child has been seen for an evaluation.

Parent or Guardian: ________________________ Date: ________________________