Alaska Neuro/Therapy Center

Anchorage: 615 E 82nd Ave, Suite 102, Anchorage, AK 99518
Wasilla: 3505 E. Meridian Park Loop, Suite 220, Wasilla Alaska 99654
Ph: 907.344.3338 Fax: 907.344.8020

Childhood History Form

Child's Name: _____ Age: _____ Sex_____
DOB:_____
Home Address: _____ Home Phone: _____
Child's School Name_____
Child's School Address _____
Grade: _____ Special Placement:_____
Parents: Never Married _____ Married _____ Divorced _____ (age of child at divorce _____)
Child: Adopted _____ (at what age_____)
Who is the child presently living with:
Natural Mother _____ Natural Father _____ Stepmother _____ Stepfather _____
Adoptive Mother _____ Adoptive Father _____ Foster Mother _____ Foster Father _____
Other (specify)_____
Non-Residential Adults involved with this child on a regular basis:
_____
_____

Source of Referral

Name _____
Address _____ Phone _____
Briefly State main problem of child _____
_____
_____

Parents

Mother_____

Occupation _____
Current Age _____ Age at time of pregnancy with patient_____
Highest Grade Completed _____
Learning problems _____
Attention problems_____
Behavior problems _____
Emotional/psychiatric problems _____
Medical problems _____
Prescriptions used for past/present psychiatric/psychological problems _____
_____
_____

Father_____

Occupation _____
Current Age _____
Highest Grade Completed _____
Learning problems _____
Attention problems_____
Behavior problems _____

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Emotional/psychiatric problems _____
Medical problems _____
Prescriptions used for past/present psychiatric/psychological problems _____
_____
_____

Siblings

Name	Age	Medical, Social, Emotional or School Problems
1.		
2.		
3.		
4.		

Any Family Stressors/Changes (relocation, separation, etc.) _____

Pregnancy – Complications

Excessive Vomiting _____ Hospitalization required _____
Excessive Blood Loss _____ Threatened Miscarriage _____
Infections (specify)_____
Toxemia _____ Operations (specify) _____
Other Illnesses (specify)_____
Smoking during Pregnancy _____ # of cigarettes per day _____
Describe your Alcoholic Consumption during pregnancy _____
Medications taken during Pregnancy _____
Duration of Pregnancy (weeks) _____

Delivery

Type of Labor: Spontaneous _____ Induced _____ Duration (Hrs) _____
Type of Delivery: Normal _____ Breech _____ Caesarean _____
Complications: Cord around Neck _____ Hemorrhage _____
Infant injured during delivery _____ Other _____
Birth Weight _____

Post Delivery

Jaundice _____ Cyanosis _____ Incubator Care _____
Infection (specify) _____
Number of days infant was in the hospital after delivery _____

Infancy Period

Were any of the following present, to a significant degree, during the first few years of life? If so, Describe?
Did not enjoy cuddling _____
Was not calmed by being held or stroked _____
Difficult to comfort _____
Colic _____
Excessive restlessness/irritability _____
Diminished Sleep _____
Frequent head banging _____
Difficult nursing/feeding _____
Constantly into everything _____

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Temperament

Please rate the following behaviors during infancy, toddlerhood, and present age:

Activity Level (How physically active is your child compared to others their age?)_____

_____

Distractibility (How easily is your child's attention diverted?) _____

_____

Adaptability (How well does your child deal with transition and change) _____

_____

Approach/Withdrawal (How well does your child respond to new things) _____

_____

Intensity (Whether happy or unhappy, how aware were/are others of your child's feelings) _____

_____

Mood (What is/was your child's basic mood) _____

_____

Regularity (How predictable is/was your child in patterns of sleep, appetite, etc.) _____

_____

Persistence and Attention (How well is/was your child able to persist in attaining a goal and to attend to one activity for a period of time) _____

_____

Medical History

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 _____

_____

Operations _____

Hospitalization for illness _____

Head Injuries _____

Convulsions _____ With Fever _____ W/o Fever _____

Persistent High Fever _____

Eye Problems _____

Tics (repetitive blinking, sniffing or non-purposeful movements) _____

Ear Problems _____

Allergies/Asthma _____

_____

Poisoning _____

Sleep

Does your child settle down to sleep _____

Sleep through the night w/o disruption _____

Does your child experience

Nightmares _____ Night Terrors _____ Sleep walking _____ Sleep talking _____

Other _____

Restless sleeper _____

Does your child snore _____

Are there any recent changes in their sleep patterns within the last six months _____

_____

Any changes in appetite in the last six months _____

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Past Medications for Behavioral/Psychological problems:

Date	Prescription	Dose	Response	Prescribing Doctor

Present Medical Status

Height_____ Weight_____

Present Illnesses currently being treated _____

_____

Current ongoing medications _____

_____

Has your child been exposed to physical, emotional or sexual abuse _____

_____

_____

_____

_____

Developmental Milestones

	Age	Early	Normal	Late
Smiled				
Sat w/o support				
Crawled				
Stood w/o support				
Walked w/o help				
Spoke 1st words				
Said Phrases				
Said Sentences				
Bladder Trained - Day				
Bladder Trained – Night				
Bowel Trained – Day				
Bowel Trained – Night				
Rode Tricycle				
Rode Bicycle- no training wheels				
Buttoned clothing				
Tied Shoes				
Named Colors				
Tell time				
Named Coins				
Said Alphabet correctly				
Began to read				

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Coordination

Rate your child on the following skills:

	Good	Average	Poor
Walking			
Running			
Throwing			
Catching			
Tying Shoelaces			
Buttoning			
Writing			
Athletic abilities			

Excessive number of accidents as compared to other children (specify)? _____

_____

Comprehension and Understanding

Do you consider your child to understand directions and situations as well as other children his or her age? If not, why? _____

_____

How would you rate your child's overall level of intelligence compared to other children?
Below Average _____ Average _____ Above Average _____

School History

Were you concerned about your child's ability to succeed in Kindergarten? If so, explain_____

_____

_____

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

	Good	Average	Poor
Nursery School			
Kindergarten			
Current Grade			

To the best of your knowledge, at what grade level is your child functioning:
Reading _____ Spelling _____ Math _____

Has your child ever repeated a grade? When? _____
Has your child been formally evaluated for learning problem or a gifted and talented program? _____

_____

Present Class Placement: Regular Class _____ Special Class (specify) _____
Is there any special counseling or remedial work your child is currently receiving? _____

_____

Describe any academic school problems _____

_____

_____

_____

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Rate your child's School Experiences related to behavior:

	Good	Average	Poor
Nursery School			
Kindergarten			
Current Grade			

As best you can, please provide a general description of your child's school progress in each grade, Use the back of this form to continue, if extra space is needed

Does your child's teacher report any of the following as significant classroom problems?
Doesn't sit still in their seat _____
Frequently gets up and walks around the classroom _____
Shouts out/Doesn't wait to be called on _____
Won't wait for their 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 any other classroom behavioral problems _____

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Peer Relationships

Does your child seek friendships with peers? _____
Is your child sought by peers for friendship? _____
Does your child primarily play with children their own age _____
Younger _____ Older _____
Has your child's behavior cause them to be neglected or rejected by peers? _____
Please describe any problems your child may have with peers _____
_____
_____
_____
_____

Home Behavior

All Children exhibit, to some degree, the behaviors listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to others his or her own age.

Behavior	Check for Yes
Fidgets w/ hands, feet or squirms in seat	
Difficulty remaining seated when required to do so	
Easily distracted by extraneous stimulation	
Difficulty waiting his turn in games or group situations	
Blurts out answers to questions before they have been completed	
Difficulty following through with instructions (not due to oppositions or failure to comprehend)	
Difficulty paying attention during tasks or play activities	
Shift from one uncompleted activity to another	
Difficulty playing quietly	
Talks excessively	
Interrupts or intrudes on others (often not purposeful or planned but impulsive)	
Does not appear to listen to what is being said	
Loses things necessary for tasks or activities at home	
Boundless energy and poor judgement	
Impulsivity (poor self-control)	
History of temper tantrums	
Outbursts of temper	
Easily frustrated	
Sloppy table manners	
Sudden Outbursts of physical abuse of other children	
Overly Anxious/worried	
Low mood/ withdrawn	
Severe sibling rivalry	
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 experience	
Poor memory	
A "different child"	

Are there activities that your child sticks with to completion? If yes, what? _____
_____

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Has your child:

Consumed alcohol	
Taken illegal drugs	
Violated the law	
Destroyed property	

How well does your child work for a short-term reward?_____
How well does your child work for a long-term reward? _____

Does your child create more problems, either purposefully or non-purposefully, within the home setting than his or her siblings? _____
_____
Does your child have difficulty benefitting from his experiences? _____
_____
Types of discipline you use with your child _____
_____
_____
Do both parents agree on disciplinary practices? _____
Is there a form of discipline that has proven effective? _____

Have you participated in a parenting class or obtained other forms of information concerning discipline and behavior management? _____
_____
_____
Have family/child participated in counseling/therapy?_____
Has your child received a psychological evaluation before? _____
If yes, please approximate dates and provider information _____
_____
_____

Interests and Accomplishments

What are your child's main hobbies and interests? _____
_____
What are your child's areas of greatest accomplishments? _____
_____
_____
What does your child enjoy doing most?_____
What does your child dislike doing most? _____
What do you like about your child _____
_____

How many hours a day does your child spend:
Watching TV _____
Video Games _____
On the internet _____

List names and addresses of any other professionals you have consulted (including primary care)

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Name	Address