

**Office use:**

Last Name: \_\_\_\_\_

Evaluation Date: \_\_\_\_\_

Evaluation Time: \_\_\_\_\_

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

Today's Date: \_\_\_\_\_

Family Name: \_\_\_\_\_ Child's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_

Home phone number: \_\_\_\_\_ Completed by: \_\_\_\_\_

Mother's Address: \_\_\_\_\_

Home phone number: \_\_\_\_\_

Father's Address: \_\_\_\_\_

Home phone number: \_\_\_\_\_

Referred by: \_\_\_\_\_

May we send a thank you letter to your referral source?  yes  no

\_\_\_\_\_ has my permission to send a thank you letter to my referral source indicating that my child has been seen for an evaluation. No other information will be released without written consent.

Parent or Gaurdian: \_\_\_\_\_ Date: \_\_\_\_\_

**FAMILY MEMBERS**

	Age	Sex	Adopted	Education/Occupation	handedness
Father	_____	_____	Yes No	_____	R L
Mother	_____	_____	Yes No	_____	R L
Children	_____	_____	Yes No	_____	R L
	_____	_____	Yes No	_____	R L
	_____	_____	Yes No	_____	R L
	_____	_____	Yes No	_____	R L

Marital Status of Parents: Married: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_ Other: \_\_\_\_\_

What are your concerns for your child?

Academic: \_\_\_\_\_  
\_\_\_\_\_

Personal: \_\_\_\_\_  
\_\_\_\_\_

Social: \_\_\_\_\_  
\_\_\_\_\_

**FAMILY ADAPTATION**

At home, how would you describe his/her general adjustment?

Poor \_\_\_\_\_ Fair \_\_\_\_\_ Good \_\_\_\_\_ Excellent \_\_\_\_\_

How does he/she 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, turn to page 5)**

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

Father \_\_\_\_\_

Mother \_\_\_\_\_

More specifically:

	Yes	No	Comments
Was it planned?	_____	_____	_____
Were there complications?	_____	_____	_____
shock	_____	_____	_____
loss of a loved one	_____	_____	_____
accident	_____	_____	_____
health problems	_____	_____	_____
confinement to bed	_____	_____	_____
tiredness, fatigue	_____	_____	_____
other	_____	_____	_____
Was mother exposed to noise?	_____	_____	_____
Did mother smoke?	_____	_____	_____
Did mother consume alcohol?	_____	_____	_____
Did mother take any medication?	_____	_____	_____
Did mother talk much?	_____	_____	_____
Was mother physically active?	_____	_____	_____
Did mother sing?	_____	_____	_____
Did mother play a musical instrument?	_____	_____	_____
Were any previous pregnancies complicated?	_____	_____	_____

Which language was spoken by mother? \_\_\_\_\_

## LABOR AND DELIVERY

Describe your experience during labor and delivery

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More specifically:

	Yes	No	Comments
Full term?	_____	_____	_____
Length of labor?	_____	_____ hrs	_____
Forceps used?	_____	_____	_____
High forceps required?	_____	_____	_____
Delivery position? (e.g. breech)	_____	_____	_____
Caesarean birth? (reason)	_____	_____	_____
Birth weight?	_____	_____	_____
APGAR rating?	_____	_____	_____
Cried immediately?	_____	_____	_____
Required special treatment? (i.e. required oxygen, had jaundice, etc.)	_____	_____	_____
Did the newborn have immediate physical contact with the mother?	_____	_____	_____
Was there a positive bonding experience between mother and newborn at birth?	_____	_____	_____
Was the newborn breastfed?	_____	_____	_____
Describe any separations from mother during first days of life	_____	_____	_____
Did mother experience any post-partum depression?	_____	_____	_____

## ADOPTION

Describe the circumstances surrounding the adoption.

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More specifically:

Age when adopted? \_\_\_\_\_

Prior foster homes? \_\_\_\_\_

Physical appearance: \_\_\_\_\_

Response to new home: \_\_\_\_\_

Is your child aware of adoption? \_\_\_\_\_

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## INFANCY

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

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More specifically:

	Yes	No	Comments
Breastfed?	_____	_____	_____
Extended separations during first two years? (over 3 days)	_____	_____	_____
Specific health problems during this period?	_____	_____	_____
Toilet trained? (age)	_____	_____	_____
Thumb sucking? (until what age)	_____	_____	_____
Feeding or sleeping problems?	_____	_____	_____

**CHILDHOOD ILLNESSES**

Has your child had any of the following childhood illnesses?

	Age	How Often
___ respiratory problems	___	_____
___ high fever	___	_____
___ meningitis	___	_____
___ ear infections	___	_____
___ adenoid problems	___	_____
___ frequent colds	___	_____
___ strep throat	___	_____
___ allergies	If yes, please list: _____	

**Has he/she ever been hospitalized?** Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list reasons:

**Has he/she ever had a serious accident/injury?** Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list accidents: \_\_\_\_\_

**Check the items below which have been a problem and give details.**

Asthma	___	_____
Bronchitis	___	_____
Skin problems	___	_____
Gastro-Intestinal problems	___	_____
Convulsions	___	_____
Epilepsy	___	_____
Nightmares	___	_____
Fitful sleep	___	_____
Bedwetting	___	_____
Nail Biting	___	_____

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

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

Is your child currently taking any prescribed medication? \_\_\_\_\_

If yes, please describe (name and dose) \_\_\_\_\_

When was your child's most recent medical check-up?

Date \_\_\_\_\_ Doctor's Name \_\_\_\_\_

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### SENSORI-MOTOR DEVELOPMENT

How would you describe your child's motor development?

Normal \_\_\_\_\_ delayed \_\_\_\_\_ advanced \_\_\_\_\_

At what age did your child: crawl \_\_\_\_\_ walk \_\_\_\_\_

develop hand preference: Right \_\_\_\_\_ Mixed \_\_\_\_\_ Left \_\_\_\_\_

Is your child unusually sensitive to touch or are some clothes "scratchy"? \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

General co-ordination? poor \_\_\_\_\_ fair \_\_\_\_\_ good \_\_\_\_\_ excellent \_\_\_\_\_

General balance: poor \_\_\_\_\_ fair \_\_\_\_\_ good \_\_\_\_\_ excellent \_\_\_\_\_

Does your child participate in sports? (type) \_\_\_\_\_

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### VISUAL DEVELOPMENT

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

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Are there any current problems of which you are aware? \_\_\_\_\_

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When was the last time his/her eyesight was tested? \_\_\_\_\_

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**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 in single words, then two, then a sentence? **or**

Did your child not talk for a long while, then all of a sudden speak in complete sentences?

First words (age) \_\_\_\_\_

Describe any speech related problems: \_\_\_\_\_

Has your child had any **previous ASSESSMENTS?**

	Yes	No	Place	Date
Medical	_____	_____	_____	_____
Audiological	_____	_____	_____	_____
Speech	_____	_____	_____	_____
Sensory Integration	_____	_____	_____	_____
Educational	_____	_____	_____	_____
Psychological	_____	_____	_____	_____

Comments: \_\_\_\_\_



Has your child been previously diagnosed as having a specific disorder?

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Has your child received any special education or special therapy?

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

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Is your marital situation stable and positive at this time?

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

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Which language (s) is spoken at home? \_\_\_\_\_

Are there other individuals or family members living at home? \_\_\_\_\_

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## EDUCATION

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

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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

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

Initial school adjustment

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Pre-school/Daycare

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Primary (K-Gr. 3)

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Junior (Gr. 4-6)

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Intermediate (Gr. 7-8)

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High School (Gr. 9-12)

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Has there been remedial help given outside the school system?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, describe:

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**BEHAVIOR/CHARACTER**

How would you describe your child?

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What are your child's strengths?

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What are your child's weaknesses?

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Have there been any specific behavior problems in the course of your child's development?

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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.

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How would you describe your child's social adjustment?

With peers?

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With adults?

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Please add any other comments you might have regarding your child's behavior and character:

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**GOALS**

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

1. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**ADDENDUM:**

If you are temporarily the child's primary caregiver, please add:

(1) The relationship you have with the child

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(2) Any additional comments you feel would be helpful

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_