

Comprehensive Child Clinical History Form

Edit Comprehensive Child Clinical History Form (1 / 21)

Introductory Information

Please let us know who referred you

May we contact them to extend a thank you for the referral?

- ☐ Yes
☐ No

Would you like us to share our findings and recommendations with them after our initial evaluation?

- ☐ Yes
☐ No

If yes, please provide contact information for the person who referred you

PARENT/GUARDIAN 1

Name:

Address:

Email:

Home phone:

Cell phone:

Work phone:

PARENT/GUARDIAN 2

Name:

Address:

Email:

Home phone:

Cell phone:

Work phone:

Person(s) completing the form

Relationship to the child

[Previous Section](#)[Save for Later](#)[Cancel](#)[Next Section](#)

Chief Complaint

What issues are you seeking help for at this time?

>>

When did you first notice these issues?

What things did you first notice?

>>

Was the onset:

- ☐ Sudden
- ☐ Gradual

Please describe any event(s) or action(s) that you or others think might have contributed to these issues (be as detailed as possible):

>>

What are your goals for the current treatment/evaluation?

>>

Current Behavior

Which of the following are concerns you have about the child? (check all that apply)

RELATIONSHIPS

☐ Problems getting along with family ☐ Problems getting along with peers ☐ Hard time talking to peers in some situations ☐ Hard time talking to non-family adults ☐ Difficulty understanding jokes ☐ Poor eye contact ☐ Self conscious; Fear of embarrassment; Shy ☐ Uncomfortable socially ☐ Fear of social situations ☐ Sensitive to crowds ☐ Stubborn ☐ Distrustful; Suspicious; Secretive ☐ Lying; Sneaking ☐ Frequent arguing ☐ Oppositional/defiant ☐ Temper tantrums; Explosive episodes

EXTERNALIZING/DISRUPTIVE

☐ Acting violently ☐ Fire setting ☐ Rule breaking ☐ Property destruction ☐ Stealing ☐ Cruelty to animals ☐ Running away ☐ Risk taking behavior ☐ Alcohol abuse ☐ Other substance abuse ☐ Abuse perpetrator

MOOD

☐ Self-esteem problems ☐ Immaturity ☐ Angry; Aggressive ☐ Irritable ☐ Self-destructive/self-abusive behaviors ☐ Suicidal talk/thoughts of killing self ☐ Suicidal behaviors; Has hurt or cut self ☐ Depression/depressed mood/sadness ☐ Tearful crying spells ☐ Feeling hopeless, helpless, and/or worthless ☐ Grief/loss ☐ Lack of energy; Fatigue ☐ Withdrawn ☐ Lack of motivation ☐ Not enjoying usual activities ☐ Difficulty making decisions ☐ Difficulty planning ahead ☐ Overwhelmed/stressed ☐ Feeling guilty ☐ Moodiness ☐ Moods change quickly ☐ Change in personality ☐ Excessively good/grandiose mood; Euphoria ☐ Excess energy ☐ Little sleep but not tired; Decreased need for sleep ☐ Racing thoughts; Flight of ideas ☐ Blackouts ☐ Hallucinations; Delusions ☐ Strange ideas or behaviors ☐ Poor awareness of time

ANXIETY

☐ Anxiety ☐ Panic attacks ☐ Obsessions or compulsions ☐ Perfectionism ☐ Rigid/inflexible ☐ Repetitive behaviors ☐ Head banging; Rocking ☐ Skin-picking ☐ Hair pulling ☐ Gets frustrated easily ☐ Abuse victim; Trauma history ☐ Worried ☐ Fear of bedtime ☐ Nightmares

LANGUAGE AND LEARNING

☐ Stuttering ☐ Involuntary vocalizations ☐ Resistance to school ☐ Learning problems; Language problems ☐ Trouble concentrating; Memory problems; Disorganization ☐ Difficulty following directions ☐ Difficulty getting started on tasks ☐ Difficulty staying on one task for a long time ☐ Difficulty with finishing a task; Difficulty completing homework ☐ Distractible; Gets easily distracted ☐ Difficulty with transitions ☐ Difficulty listening ☐ Impulsiveness ☐ Bouts of excessive energy; Always in motion; Excessively fidgety; Hyperactive ☐ Talkative ☐ Poor judgment ☐ Poor handwriting

PHYSICAL

☐ Tics/twitching ☐ Been pregnant ☐ Had an abortion; Partner had an abortion ☐ Sexual problems ☐ Dizziness; Seizures ☐ Pain/body complaints ☐ Sensory issues ☐ Blank spells; Fainting spells ☐ Bed wetting; Soiling ☐ Breath holding ☐ Change in sleep habits; Difficulty sleeping; Difficulty waking ☐ Change in eating habits/appetite; Significant weight changes ☐ Eating problems; Overeating; Eating too little; Eating disorder ☐ Eats paint, paper, etc. ☐ Nail biting; Thumb sucking ☐ Toileting problems ☐ Uncoordinated; Clumsy using hands; Clumsy walking ☐ Frequent urinary accidents

If you have other concerns not listed above, please note them here:

If any of the above behaviors were significant issues which have now gone away, please describe:

Please note the degree of impairment in the child's:	None	Mild	Moderate	Marked	Extreme
Family relationships	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
School performance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Friendships/Peer relationships	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hobbies/Play activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Daily self-care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eating habits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleeping habits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How would you describe the child's conscience?

- ☐ Normal
☐ Lax
☐ Preoccupied with Issues

Overall, how concerned are you with the child's behavior over the last few months?

- ☐ Not at All
☐ Mildly
☐ Moderately
☐ Extremely

Please note any important additional information regarding the child's current behaviors:

Previous Section

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Cancel

Next Section

Review of Systems

Please look at the list of physical symptoms below and check off any that you have experienced in the last several days. If you have NOT experienced any symptoms in an area, be sure to check "None of the above" for that area. If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Constitutional	Eyes	Ears, Nose, Mouth, and Throat
<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Earache
<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Eye discharge	<input type="checkbox"/> Tinnitus (Ringing in ears)
<input type="checkbox"/> Increase in appetite	<input type="checkbox"/> Eye redness	<input type="checkbox"/> Decreased hearing or hearing loss
<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Blurred or double vision	<input type="checkbox"/> Frequent ear infections
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Visual change	<input type="checkbox"/> Frequent nose bleeds
<input type="checkbox"/> Fatigue/Lethargy	<input type="checkbox"/> History of eye surgery	<input type="checkbox"/> Sinus congestion
<input type="checkbox"/> Unexplained fever	<input type="checkbox"/> Sensitivity to light	<input type="checkbox"/> Runny nose/Post-nasal drip
<input type="checkbox"/> Hot or Cold spells	<input type="checkbox"/> Scotomas (Blind spots)	<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Retinal hemorrhage (Floaters in vision)	<input type="checkbox"/> Frequent sore throat
<input type="checkbox"/> Sleeping pattern disruption	<input type="checkbox"/> Amaurosis fugax (Feeling like a curtain is pulled over vision)	<input type="checkbox"/> Prolonged hoarseness
<input type="checkbox"/> Malaise (Flu-like or Vague sick feeling)		<input type="checkbox"/> Pain in jaw or tooth
		<input type="checkbox"/> Dry mouth
Other: <input type="text"/>	Other: <input type="text"/>	Other: <input type="text"/>
<input type="checkbox"/> None of the above constitutional issues	<input type="checkbox"/> None of the above eye issues	<input type="checkbox"/> None of the above ear, nose, mouth or throat issues

Cardiovascular	Respiratory	Musculoskeletal
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Pain with breathing	<input type="checkbox"/> Swelling in joints
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Redness of joints
<input type="checkbox"/> Palpitations (fast or irregular heartbeat)	<input type="checkbox"/> Chronic shortness of breath	<input type="checkbox"/> Other joint pains or stiffness
<input type="checkbox"/> Swollen feet or hands	<input type="checkbox"/> Chronic wheezing/Asthma	<input type="checkbox"/> Muscle pain or cramping
<input type="checkbox"/> Fainting spells	<input type="checkbox"/> Excessive phlegm	<input type="checkbox"/> Muscle weakness
	<input type="checkbox"/> Coughing blood	<input type="checkbox"/> Muscle stiffness
<input type="checkbox"/> Shortness of breath with exercise	<input type="checkbox"/> Nocturnal Dyspnea (Shortness of breath at night)	<input type="checkbox"/> Decreased range of motion
		<input type="checkbox"/> Back pain or stiffness
		<input type="checkbox"/> History of fractures
		<input type="checkbox"/> Past injury to spine or joints
Other: <input type="text"/>	Other: <input type="text"/>	Other: <input type="text"/>
<input type="checkbox"/> None of the above cardiovascular issues	<input type="checkbox"/> None of the above respiratory issues	<input type="checkbox"/> None of the above musculoskeletal issues
Gastrointestinal		
<input type="checkbox"/> Excessive flatulence or belching	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Change in appearance of stool
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Difficulty swallowing solids or liquids	<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Constipation	<input type="checkbox"/> Recent loss in appetite	<input type="checkbox"/> Dark/Tarry stool
<input type="checkbox"/> Persistent nausea/vomiting	<input type="checkbox"/> Sensitivity to milk products	<input type="checkbox"/> Loss of bowel control/soiling
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Jaundice (yellow skin)	
Other: <input type="text"/>		<input type="checkbox"/> None of the above gastrointestinal issues












Allergic/Immunologic	Endocrine	Hematologic/Lymphatic
<input type="checkbox"/> Frequent infections	<input type="checkbox"/> Severe menopausal symptoms	<input type="checkbox"/> Blood clots
<input type="checkbox"/> Hives	<input type="checkbox"/> Cold or heat intolerance	<input type="checkbox"/> Excess/easy bleeding (surgery, dental work, brushing teeth, scrapes)
<input type="checkbox"/> Anaphylactic reaction	<input type="checkbox"/> Excessive appetite	<input type="checkbox"/> History of blood transfusion
	<input type="checkbox"/> Excessive thirst or urination	<input type="checkbox"/> Excessive bruising
	<input type="checkbox"/> Excessive sweating	<input type="checkbox"/> Swollen glands (neck, armpits, groin)
Other: <input type="text"/>	Other: <input type="text"/>	Other: <input type="text"/>
<input type="checkbox"/> None of the above allergic or immunologic issues	<input type="checkbox"/> None of the above endocrine issues	<input type="checkbox"/> None of the above hematologic or lymphatic issues
Genitourinary (General)	Genitourinary (Women)	Genitourinary (Men)
<input type="checkbox"/> Loss of urine control (including bed-wetting)	<input type="checkbox"/> Unusual vaginal discharge	<input type="checkbox"/> Slow urine stream
<input type="checkbox"/> Painful/Burning urination	<input type="checkbox"/> Vaginal pain, bleeding, soreness, or dryness	<input type="checkbox"/> Scrotal pain
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Genital sores	<input type="checkbox"/> Lump or mass in the testicles
<input type="checkbox"/> Increased frequency of urination	<input type="checkbox"/> Heavy or irregular periods	<input type="checkbox"/> Abnormal penis discharge
<input type="checkbox"/> Up more than twice/night to urinate	<input type="checkbox"/> No menses (Periods stopped)	<input type="checkbox"/> Trouble getting/maintaining erections
<input type="checkbox"/> Urine retention	<input type="checkbox"/> Currently pregnant	<input type="checkbox"/> Inability to ejaculate/orgasm
<input type="checkbox"/> Frequent urine infections	<input type="checkbox"/> Sterility/Infertility	<input type="checkbox"/> Any other sexual or sex organ concerns
	<input type="checkbox"/> Any other sexual or sex organ concerns	
Other: <input type="text"/>	Other: <input type="text"/>	Other: <input type="text"/>
<input type="checkbox"/> None of the above general genitourinary issues	<input type="checkbox"/> None of the above sex-specific genitourinary issues	<input type="checkbox"/> None of the above sex-specific genitourinary issues

Neurological	Integumentary (Skin/Breast and Hair)	Psychiatric
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Lesions	<input type="checkbox"/> In-depth review of psychiatric system appears earlier in document (to be checked by clinician only)
<input type="checkbox"/> Fainting spells or blackouts	<input type="checkbox"/> Unusual mole	<input type="checkbox"/> Feeling depressed
<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Difficulty concentrating
<input type="checkbox"/> Drowsiness	<input type="checkbox"/> Increased perspiration	<input type="checkbox"/> Phobias/Unexplained fears
<input type="checkbox"/> Slurred speech	<input type="checkbox"/> Rashes	<input type="checkbox"/> No pleasure from life anymore
<input type="checkbox"/> Speech problems (other)	<input type="checkbox"/> Chronic dry skin	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Short term memory trouble	<input type="checkbox"/> Itchy skin or scalp	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Memory difficulties (loss)	<input type="checkbox"/> Hair or nail changes	<input type="checkbox"/> Excessive moodiness
<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Hair loss	<input type="checkbox"/> Stress
<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Breast tenderness	<input type="checkbox"/> Disturbing thoughts
<input type="checkbox"/> Numbness/Tingling sensations	<input type="checkbox"/> Breast discharge	<input type="checkbox"/> Manic episodes
<input type="checkbox"/> Neuropathy (numbness in feet)	<input type="checkbox"/> Breast lump or mass	<input type="checkbox"/> Confusion
<input type="checkbox"/> Tremor in hands/shaking		<input type="checkbox"/> Memory loss
<input type="checkbox"/> Muscle spasms or tremors		<input type="checkbox"/> Nightmares
Other: <input type="text"/>	Other: <input type="text"/>	Other: <input type="text"/>
<input type="checkbox"/> None of the above neurological issues	<input type="checkbox"/> None of the above integumentary issues	<input type="checkbox"/> None of the above psychiatric issues












[Previous Section](#)
[Save for Later](#)
[Cancel](#)
[Next Section](#)

Mental Health Treatment/Evaluation History

Therapy/Treatments/Interventions

Has the child ever received any of the following therapies privately or in school? (please check all that apply):	Approximate dates	Inpatient/Outpatient?	Provider/Facility Name & Contact Information	Describe reasons for going	Describe progress noted
<input type="checkbox"/> Psychiatric treatment		- Select One- 			
<input type="checkbox"/> Psychological treatment		- Select One- 			
<input type="checkbox"/> Counseling		- Select One- 			
<input type="checkbox"/> Group therapy		- Select One- 			
<input type="checkbox"/> Family therapy		- Select One- 			
<input type="checkbox"/> Behavioral interventions		- Select One- 			
<input type="checkbox"/> Neurofeedback		- Select One- 			
<input type="checkbox"/> Physical therapy		- Select One- 			
<input type="checkbox"/> Occupational therapy		- Select One- 			
<input type="checkbox"/> Speech & language therapy		- Select One- 			
<input type="checkbox"/> Other <input type="text"/>		- Select One- 			

Evaluations/Assessments

Has the child ever had any of the following assessments/evaluations performed privately or in school? (please check all that apply) IF APPLICABLE, PLEASE BRING PRIOR REPORT(S) TO YOUR APPOINTMENT	Approximate dates	Inpatient/Outpatient?	Evaluator/Facility Name & Contact Information	Describe reasons for going	Describe progress noted
<input type="checkbox"/> Learning/academic/IQ		- Select One- 			
<input type="checkbox"/> Psychiatric		- Select One- 			
<input type="checkbox"/> Psychological		- Select One- 			
<input type="checkbox"/> Developmental		- Select One- 			
<input type="checkbox"/> Physical		- Select One- 			
<input type="checkbox"/> Neuropsychological		- Select One- 			
<input type="checkbox"/> Occupational		- Select One- 			
<input type="checkbox"/> Speech & language		- Select One- 			
<input type="checkbox"/> Audiology		- Select One- 			
<input type="checkbox"/> Neurological (e.g., MRI, CAT scan, EEG, etc.)		- Select One- 			
<input type="checkbox"/> Other <input type="text"/>		- Select One- 			

Previous Diagnoses

Has the child ever been given any of the following diagnoses? (please check all that apply):	Approximate date	At what age was this first diagnosed?	Comments
<input type="checkbox"/> ADHD/ADD	<input type="text"/>	- Select One- <input type="button" value="v"/>	<input type="text"/>
<input type="checkbox"/> Anxiety	<input type="text"/>	- Select One- <input type="button" value="v"/>	<input type="text"/>
<input type="checkbox"/> Auditory Processing Disorder	<input type="text"/>	- Select One- <input type="button" value="v"/>	<input type="text"/>
<input type="checkbox"/> Autism Spectrum Disorder or Asperger's Syndrome	<input type="text"/>	- Select One- <input type="button" value="v"/>	<input type="text"/>
<input type="checkbox"/> Bipolar or Manic-Depressive Disorder	<input type="text"/>	- Select One- <input type="button" value="v"/>	<input type="text"/>
<input type="checkbox"/> Depression	<input type="text"/>	- Select One- <input type="button" value="v"/>	<input type="text"/>
<input type="checkbox"/> Developmental delay	<input type="text"/>	- Select One- <input type="button" value="v"/>	<input type="text"/>
<input type="checkbox"/> Hearing impairment	<input type="text"/>	- Select One- <input type="button" value="v"/>	<input type="text"/>
<input type="checkbox"/> Learning disability	<input type="text"/>	- Select One- <input type="button" value="v"/>	<input type="text"/>
<input type="checkbox"/> Non-verbal Learning Disorder (NVLD)	<input type="text"/>	- Select One- <input type="button" value="v"/>	<input type="text"/>
<input type="checkbox"/> Obsessive-Compulsive Disorder	<input type="text"/>	- Select One- <input type="button" value="v"/>	<input type="text"/>
<input type="checkbox"/> Oppositional-Defiant Disorder	<input type="text"/>	- Select One- <input type="button" value="v"/>	<input type="text"/>
<input type="checkbox"/> Pervasive Developmental Disorder (PDD)	<input type="text"/>	- Select One- <input type="button" value="v"/>	<input type="text"/>
<input type="checkbox"/> Selective Mutism	<input type="text"/>	- Select One- <input type="button" value="v"/>	<input type="text"/>
<input type="checkbox"/> Sensory Processing/Integration Disorder	<input type="text"/>	- Select One- <input type="button" value="v"/>	<input type="text"/>
<input type="checkbox"/> Tourette's Disorder	<input type="text"/>	- Select One- <input type="button" value="v"/>	<input type="text"/>
<input type="checkbox"/> Visual impairment	<input type="text"/>	- Select One- <input type="button" value="v"/>	<input type="text"/>
<input type="checkbox"/> Other <input type="text"/>	<input type="text"/>	- Select One- <input type="button" value="v"/>	<input type="text"/>

Please note any important additional information regarding the child's mental health treatment/evaluation history:

Psychiatric Medication History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Have you ever taken any medication for psychiatric treatment?

☐ Yes

☐ No

If YES, please fill out the table below to the best of your knowledge:

Medication name	Dose	How long? (months)	End Date	Therapeutic effect	Side Effects	Reason for stopping?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<div>- Select One -<div></div></div>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<div>- Select One -<div></div></div>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<div>- Select One -<div></div></div>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<div>- Select One -<div></div></div>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<div>- Select One -<div></div></div>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<div>- Select One -<div></div></div>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<div>- Select One -<div></div></div>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<div>- Select One -<div></div></div>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<div>- Select One -<div></div></div>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<div>- Select One -<div></div></div>	<input type="text"/>	<input type="text"/>

Previous Section

Save for Later

Cancel

Next Section

Medical History

Current Physical Health & Healthcare

Pediatrician's/primary care physician's name:

Pediatrician's/primary care physician's phone number:

Pediatrician's/primary care physician's address:

Pediatrician's/primary care physician's fax number:

Pediatrician's/primary care physician's email address:

Would you like us to contact the child's pediatrician/primary care physician?

- ☐ Yes
☐ No

What was the date of the child's last physical exam?

Was blood work done?

- ☐ Yes
☐ No

The child's current physical health is:

- ☐ Poor
☐ Fair
☐ Good
☐ Excellent

Medical Conditions and Procedures

Please check off whether the child has ever experienced any of the following and/or complains of any of the following conditions (check all that apply):

☐ Aches or pains ☐ Adenoidectomy ☐ Anemia ☐ Asthma ☐ Braces or other orthodontic appliances ☐ Bronchitis ☐ Chest pain ☐ Chicken pox ☐ Chronic constipation ☐ Cold hands/feet ☐ Cold intolerant ☐ Coma ☐ Concussion ☐ Deformities ☐ Diabetes ☐ Difficulty breathing ☐ Dizziness ☐ Ear infections ☐ Ear tubes ☐ Encephalitis ☐ Failure to grow ☐ Flushing ☐ Frequent colds ☐ Frequent fever ☐ Frequent headaches ☐ Gastrointestinal condition (e.g., Chron's disease, ulcerative colitis, inflammatory bowel disease, gastroesophageal reflux disease) ☐ Genetic condition (e.g., sickle cell disease, PKU) ☐ Head injury which required medical attention ☐ Heart defects

☐ Heat intolerant ☐ Loss of consciousness ☐ Meningitis ☐ Menstrual problems ☐ Mononucleosis (mono) ☐ Measles ☐ Mumps ☐ Nausea ☐ Numbness in extremities ☐ Obesity ☐ Painful urination ☐ Palpitations ☐ PCOS ☐ Physical trauma ☐ Pneumonia ☐ Poisoning ☐ Rubella ☐ Rubeola ☐ Seizures ☐ Sinus infections ☐ Skin problems ☐ Sleep problems ☐ Stomachaches ☐ Stomach problems ☐ Strep throat ☐ Thrush ☐ Thyroid problem ☐ Tiredness ☐ Tonsillectomy ☐ Trouble with hearing ☐ Trouble with vision ☐ Vomiting ☐ Weakness ☐ Whooping cough ☐ Movement problems (tics, repetitive movements, etc.) ☐ Other:

Please describe any of the conditions checked above (including age of child when the condition, incident, or illness occurred, and how frequently the complaints occur - where applicable):

Please answer the following questions:	Yes or No	If yes, please describe (including age of child and reasons for procedures, where relevant):
Is the child currently under treatment for any of the conditions noted above?	<div>- Select</div>	<div></div>
Has the child experienced any other injuries not noted above?	<div>- Select</div>	<div></div>
Has the child ever been hospitalized?	<div>- Select</div>	<div></div>
Has the child ever had any surgeries or operations?	<div>- Select</div>	<div></div>
	<div>- Select</div>	
Has the child ever had a neurological evaluation (e.g., exam, MRI, CAT scan, EEG)?		<div></div>

Please list and describe any other current or past medical diagnoses or conditions:

Medications

Please list all of the child's current medications and previous medications that were taken for more than one month (include prescription and over-the-counter):

Name of medication: <div></div>	When used: <div>- Select One-</div>	Reason for taking: <div></div>	Main effects (if any): <div></div>	Name of person who prescribed the medication: <div></div>
Dose: <div></div>			Side effects (if any): <div></div>	
Name of medication: <div></div>	When used: <div>- Select One-</div>	Reason for taking: <div></div>	Main effects (if any): <div></div>	Name of person who prescribed the medication: <div></div>
Dose: <div></div>			Side effects (if any): <div></div>	
Name of medication: <div></div>	When used: <div>- Select One-</div>	Reason for taking: <div></div>	Main effects (if any): <div></div>	Name of person who prescribed the medication: <div></div>
Dose: <div></div>			Side effects (if any): <div></div>	

Does the child follow the medication regime?

- ☐ Yes
- ☐ No
- ☐ Not applicable

Please list all of the child's current supplements (e.g., vitamins) or alternative/herbal therapies:

Name of supplement or therapy	Dose	Reason for taking
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Vision

Does the child have any vision or eye problems?

- ☐ Yes
☐ No

If yes, please describe:

Does the child wear glasses?

- ☐ Yes
☐ No

If yes, for what reason(s):

Date of last vision screen:

Results of last vision screen:

Hearing

Does the child have any hearing problems?

- ☐ Yes
☐ No

If yes, please describe:

Date of last hearing screen:

Results of last hearing screen:

Allergies

Does the child have any known allergies to medications, foods, animals, etc.?

- ☐ Yes
☐ No

If yes, please describe:

Immunizations/Vaccinations

Are the child's immunizations up to date?

- ☐ Yes
☐ No

Please note any important additional information regarding the child's physical health and/or medical history:

Previous Section

Save for Later

Cancel

Next Section

Edit Comprehensive Child Clinical History Form (8 / 21)

Menstruation and Pregnancy History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

At what age did you begin menstruation?

Which of these best describe your premenstrual symptoms?

- ☐ None of these
☐ Dysphoria
☐ Cramps
☐ Appetite change
☐ bloating
☐ Sleep disturbance

Do you have a method of contraception? (check all that apply)

- ☐ No method of contraception
☐ Intrauterine (e.g., IUD)
☐ Hormonal (e.g., implant, injection, "the pill," patch, hormonal vaginal contraceptive ring)
☐ Barrier (e.g., diaphragm, male/female condom, spermicide)
☐ Fertility Awareness-based (e.g., natural family planning)
☐ Permanent (e.g., male/female sterilization, infertility)
☐ Other:

Have you ever been pregnant?

- ☐ Yes
☐ No

If YES, how many times?

Have you ever given birth?

- ☐ Yes
☐ No

If YES, how many times?

Have you had any miscarriages?

☐ Yes

☐ No

If YES, how many times?

Have you had any abortions?

☐ Yes

☐ No

If YES, how many times?

Previous Section

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Cancel

Next Section

Edit Comprehensive Child Clinical History Form (9 / 21)

Family Mental Health/Social History

Please note if any of the child's family members have experienced and/or been diagnosed with any of the following (check all that apply):	Which family member(s)? (for example, Mother, Sibling, Uncle, Cousin)	Is/was one or more of the family members BIOLOGICALLY related to the child?	Timing
<input type="checkbox"/> Depression	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Bipolar/Manic-Depressive Disorder	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Suicide or attempt(s)	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Anxiety	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Panic Attacks	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Obsessive-Compulsive Disorder	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Tourette syndrome/Tic Disorder	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Autism/Asperger's syndrome/Pervasive Developmental Disorder (PDD)	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> "Absent Minded Professor" Stereotype	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Developmental Delays/Mental Retardation	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> ADHD/Attention Difficulties	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Hyperactivity (especially as a child)	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Schizophrenia	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Psychosis or Thought Problems	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Learning Disabilities/Difficulties; Reading Disorder/Dyslexia	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>

<input type="checkbox"/> Kept Back in School	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Special Education	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Speech Problems (especially as a child)	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Bedwetting/Bowel Movement Withholding	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Aggressive or Violent Behaviors	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Erratic Temper; Moods Quickly Change	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Physical or Sexual Abuse	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Alcohol Abuse/Dependence	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Other Substance Abuse/Dependence	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Social Difficulties	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Problems Keeping a Job	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Legal Trouble/Problems or Police Contact	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Frequently in Trouble as a Child/Teenager	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Outpatient Psychotherapy	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Inpatient Psychiatric Treatment	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Other <input type="text"/>	<input type="text"/>	- Select One- 	- Select 

If any of the above were checked, please briefly describe:




Please note any important additional information regarding family mental health and/or social history:




Previous Section

















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Next Section

Family Medical History

Please note if any of the child's family members have experienced and/or been diagnosed with any of the following (check all that apply):	Which family member(s) (for example, Mother, Sibling, Uncle, Cousin)	Is/was one or more of the family members BIOLOGICALLY related to the child?	Timing
<input type="checkbox"/> Birth defects	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Blood problems	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Brain disease	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Cancer	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Diabetes	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Eating disorders	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Gastrointestinal problems	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Hearing problems	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Heart rhythm problems	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Hospitalizations	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Kidney problems	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Liver problems	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Movement problems (e.g., slowness in walking)	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Neurofibromatosis	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Neurological disorder/problems	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>
<input type="checkbox"/> Other heart problems	<input type="text"/>	- Select One- <input type="button" value="v"/>	- Select <input type="button" value="v"/>

<input type="checkbox"/> Seizures	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Speech problems (e.g., slowness in talking)	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Sudden cardiac death (for persons under 60 years of age)	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Sudden unexplained death (for persons under 60 years of age)	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Thyroid disease	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Visual problems	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Weight-related problems	<input type="text"/>	- Select One- 	- Select 
<input type="checkbox"/> Other <input type="text"/>	<input type="text"/>	- Select One- 	- Select 

If any of the above were checked, please briefly describe:

Please note any important additional information regarding family medical history:

Previous Section

Save for Later

Cancel

Next Section

Edit Comprehensive Child Clinical History Form (11 / 21)

Prenatal Development and Birth History


Prenatal Development

Please select all that apply to the child's prenatal development:

- ☐ The mother had prenatal care while pregnant with the child
- ☐ The child was conceived through in vitro fertilization
- ☐ The mother received medicines to increase fertility


- ☐ The child was a multiple birth

If so, was the child born:

- Select One - 

- ☐ The mother had previous pregnancies

If so, how many previous pregnancies (not including this child)?

- Select One- 

Number of ultrasounds during pregnancy:

Please describe any abnormal findings:

Pregnancy Complications

Please check off any of the following complications experienced by the mother while pregnant with the child:

- ☐ Anemia ☐ Bleeding ☐ Chronic illness ☐ Excessive vomiting ☐ German measles ☐ High blood pressure ☐ Infection(s) ☐ Injury
☐ Preeclampsia ☐ Premature labor ☐ RH incompatibility ☐ Surgery ☐ Threatened miscarriage ☐ Toxemia ☐ Other

Please describe any of the complications marked above:

Please list any medications prescribed to the mother during pregnancy:

Mother's Health Habits While Pregnant

Did the mother use any of the following while pregnant? (please check all that apply):

- ☐ Caffeine ☐ Tobacco ☐ Alcohol ☐ Recreational drugs ☐ Prescription medication/medical treatment other than routine prenatal care
☐ Other

Please describe the items selected above (including types and frequency of usage):

If the mother had any dietary restrictions while pregnant, please describe:

Birth/Delivery/Post-Delivery

	Mother	Father
Parents' ages at time of delivery:	<input type="text"/>	<input type="text"/>

How long was labor (i.e., how many hours from first contractions to birth)? Please only list the number of hours (for example, "8")

Was the mother under anesthesia during delivery?

- ☐ No
☐ Local
☐ Spinal
☐ General

Was the child born:

- ☐ On Time
☐ Early
☐ Late

If early or late, by how many days?

How much did the baby weigh at the time of delivery? (Please enter weight in pounds and ounces)	Was the baby normally active?	What were the baby's Apgar scores?
<input type="text"/> <input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No	1 minute: <input type="text"/> - Select One- <input type="button" value="v"/> 5-minute: <input type="text"/> - Select One- <input type="button" value="v"/>

Please check off any of the following items that pertained to the child during delivery and post delivery:

- ☐ Abnormal color ☐ Baby did not cry right away ☐ Birth defect ☐ Breeched ☐ Cesarean ☐ Cord around neck ☐ Difficulty breathing
☐ Fetal distress ☐ Induced ☐ Jaundice ☐ Natural childbirth ☐ Needed a respirator ☐ Received oxygen ☐ Received phototherapy
☐ Received transfusions ☐ Seizure ☐ Use of forceps ☐ Other

Please describe any additional complications:

Where was the baby born?

- ☐ Hospital
☐ At Home
☐ Other

If other, please specify:

If the baby was born in a hospital, how many days was the baby in the hospital after delivery? Please only list the number of days (for example, "2")

If the baby was born in a hospital, did mother and baby leave the hospital together?

- ☐ Yes
☐ No

If no, please provide the reason:

After birth, did the baby stay in:

- ☐ N/A
☐ Well-baby Nursery
☐ Neonatal Intensive Care Unit (NICU)
☐ Other

If other, please specify:

Please describe any medical problems the child had in the first few days/weeks of life:

Did either parent have significant problems adjusting after the birth (including if mother had problems with depression)?

- ☐ Yes
☐ No

If yes, please describe:

Adoption

Was the child adopted?

- ☐ Yes
☐ No

If yes, please answer the following:

How old was the child when placed in the adopted parents' care?

Please briefly describe the pre-adoption environment:

Please briefly describe the circumstances of the adoption:

Please note any important additional information regarding the child's prenatal development or birth history:

Previous Section

Save for Later

Cancel

Next Section

Developmental History

Early Development

Please check off any of the following items that describe the child in infancy, toddlerhood, and/or preschool:

☐ Active baby ☐ Anemia ☐ Asthma ☐ Bad foot odor ☐ Bed wetting ☐ Chronic sniffles ☐ Constipation ☐ Convulsions ☐ Cradle cap ☐ Defiant ☐ Diaper rash ☐ Diarrhea ☐ Did not enjoy cuddling ☐ Difficult to soothe ☐ Difficulty chewing ☐ Difficulty sleeping ☐ Difficulty sucking ☐ Disconnected socially ☐ Eczema or psoriasis ☐ Excessive tantrums ☐ Excessively irritable ☐ Excessively restless ☐ Failure to thrive ☐ Fears/phobias ☐ Finicky eating ☐ Growing pains ☐ Hyperactivity ☐ Jaundice ☐ Limp ☐ Nightmares ☐ Not calmed by being held; Difficult to comfort ☐ Poor muscle control ☐ Poor muscle tone ☐ Poor teeth ☐ Poor weight gain ☐ Sensory issues ☐ Stiff ☐ Stomachaches ☐ Tremors ☐ Under responsive ☐ Very sweaty ☐ Warts ☐ Other

Was the baby (check all that apply):

- ☐ Colicky
☐ Breast fed
☐ Bottle fed
☐ On a special diet

If yes to any item above, please describe and specify how long for each:

Please describe any other feeding issues (e.g., sensitivities; textures; reflux; resistance; difficulty swallowing; drooling, etc.):

⬆
⬇

Was the child an "easy baby" who did not cry easily and was flexible?

- ☐ Yes, very much so
☐ Yes, pretty easy
☐ Probably about average
☐ No, pretty difficult
☐ No, extremely difficult

When the child was a baby, how was s/he with other people?

- ☐ Above average
☐ Very wary of strangers, very upset if held by or left with others
☐ Indifferent to strangers, no reaction if held by or left with others

Was the child an active infant/toddler?
















- ☐ Low energy, usually quiet and inactive
☐ Not very active
☐ About average
☐ Quite active
☐ Extremely restless and active, into everything













As an infant/toddler, how insistent was the child when s/he wanted something?



- ☐ Not insistent at all
☐ Not very insistent
☐ About average
☐ Somewhat insistent
☐ Very insistent

Developmental Milestones

Please note when the following milestones were achieved (enter years and months in separate columns; for example, if the child achieved a milestone at 2 years and 3 months, enter "2" in the first column and "3" in the second):

Motor Development	Age - years (optional)	Age - months (optional)	Timing
Rolled over	<input type="text"/>	<input type="text"/>	- Select One- 
Sat without support	<input type="text"/>	<input type="text"/>	- Select One- 
Grasped pencil/crayon	<input type="text"/>	<input type="text"/>	- Select One- 
Scribbled with a crayon	<input type="text"/>	<input type="text"/>	- Select One- 
Crawled	<input type="text"/>	<input type="text"/>	- Select One- 
Stood up	<input type="text"/>	<input type="text"/>	- Select One- 
Walked holding on	<input type="text"/>	<input type="text"/>	- Select One- 
Walked without holding on	<input type="text"/>	<input type="text"/>	- Select One- 
Fed self	<input type="text"/>	<input type="text"/>	- Select One- 
Drank from a cup	<input type="text"/>	<input type="text"/>	- Select One- 
Dressed self	<input type="text"/>	<input type="text"/>	- Select One- 
Tied shoes	<input type="text"/>	<input type="text"/>	- Select One- 
Pedaled tricycle	<input type="text"/>	<input type="text"/>	- Select One- 
Rode bike	<input type="text"/>	<input type="text"/>	- Select One- 
Swam	<input type="text"/>	<input type="text"/>	- Select One- 

Language Development	Age - years (optional)	Age - months (optional)	Timing
Babbled	<input type="text"/>	<input type="text"/>	- Select One- 
Spoke single words	<input type="text"/>	<input type="text"/>	- Select One- 
Spoke two word phrases	<input type="text"/>	<input type="text"/>	- Select One- 
Spoke in short sentences	<input type="text"/>	<input type="text"/>	- Select One- 
Responded to another person's smile by smiling back	<input type="text"/>	<input type="text"/>	- Select One- 
Communicated wants by pointing, gesturing, etc.	<input type="text"/>	<input type="text"/>	- Select One- 
Imitated others' behavior	<input type="text"/>	<input type="text"/>	- Select One- 
Identified words that rhyme	<input type="text"/>	<input type="text"/>	- Select One- 
Started to read	<input type="text"/>	<input type="text"/>	- Select One- 
Differentiated left from right	<input type="text"/>	<input type="text"/>	- Select One- 
Followed commands	<input type="text"/>	<input type="text"/>	- Select One- 
Easily understood by others (not family members)	<input type="text"/>	<input type="text"/>	- Select One- 

Toileting	Age - years (optional)	Age - months (optional)	Timing
Trained for urine	<input type="text"/>	<input type="text"/>	- Select One- 
Trained for bowels	<input type="text"/>	<input type="text"/>	- Select One- 

GROWTH

Please select the child's MOST RECENT height and weight percentiles:

Height:

- ☐ Don't Know
- ☐ Below 3rd percentile
- ☐ 3rd-10th percentile
- ☐ 11th-24th percentile
- ☐ 25th-75th percentile
- ☐ Above 75th percentile

Weight:

- ☐ Don't Know
- ☐ Below 3rd percentile
- ☐ 3rd-10th percentile
- ☐ 11th-24th percentile
- ☐ 25th-75th percentile
- ☐ Above 75th percentile

What was the child's age (in years) when these percentiles were measured? (Please only enter the number; for example, "8")

Have you or the child's pediatrician ever been concerned about the child's rate of growth, height, or weight?

- ☐ Yes
- ☐ No

If yes, please describe:

Language Development

☐ There have been no concerns (if no concerns, please skip to Sensorimotor Development section)

Please check off the following items that relate to the child's language (check all that apply):

- ☐ Avoids being read to
- ☐ Does not enjoy listening to stories
- ☐ Gets frustrated when explaining things orally
- ☐ Has a hard time asking for help or making his/her wants and needs known to others
- ☐ Has a hard time expressing his/her ideas
- ☐ Leaves off endings (e.g., plurals, -ed) when speaking in sentences
- ☐ Leaves off small words (e.g., the, is, to) when speaking in sentences
- ☐ Mispronounces words or leaves off sounds in words
- ☐ Names things incorrectly
- ☐ Often asks others to repeat what they have said
- ☐ Repeats sounds, words, or phrases over and over
- ☐ Talks around an issue without coming to the point
- ☐ Trouble finding words s/he wants to use
- ☐ Unable to follow one step directions
- ☐ Unable to follow multi-step directions
- ☐ Unable to remember short messages
- ☐ Unable to respond correctly to who/what/where/when/why questions
- ☐ Unable to respond correctly to yes/no questions
- ☐ Unable to understand what people are saying
- ☐ Other

If other, please describe:

Is the child's speech (check all that apply):

- ☐ Usually soft
- ☐ Usually loud
- ☐ Hoarse, breathy, or strained-sounding
- ☐ Dysfluent (e.g., stuttering)
- ☐ Filled with "um" and "you know"
- ☐ Unable to be understood by familiar others
- ☐ Unable to be understood by unfamiliar others

The child currently communicates using (check all that apply):

- ☐ Body language
- ☐ Sounds (e.g., vowels and vocalizations)
- ☐ Single words
- ☐ 2 to 4 word sentences
- ☐ Full sentences
- ☐ Other

If other, please describe:

Was the child ever recommended to have speech or language therapy?

- ☐ Yes
☐ No

Has the child ever had speech or language therapy?

- ☐ Yes
☐ No

If the child has had speech or language therapy, please specify where and when. If possible, please give any information related to goals at that time or currently.

Was the child ever recommended to have occupational therapy (OT)?

- ☐ Yes
☐ No

Has the child ever had occupational therapy (OT)?

- ☐ Yes
☐ No

If the child has had occupational therapy (OT), please specify where and when. If possible, please give any information related to goals at that time or currently.

Sensorimotor Development

☐ There have been no concerns (if no concerns, please skip to Toileting section)

Please check off the following items that relate to the child's sensory and motor skills (check all that apply):

TACTILE (TOUCH):

☐ Has trouble managing personal/physical space ☐ Over sensitive to clothing/textures/foods ☐ Under sensitive to clothing/textures/foods

VISUAL:

☐ Avoids eye contact with others ☐ Did not pass most recent vision screening ☐ Has trouble copying words from the board ☐ Has trouble tracking objects with eyes

AUDITORY (SOUND):

☐ Did not pass most recent hearing screening ☐ Fails to listen or pay attention to what is said to him/her ☐ Has difficulty if 2 or 3 step instructions are given at once ☐ History of frequent ear infections ☐ History of PE tubes in his/her ears ☐ Sensitive to loud sounds (e.g., school bells, sirens) ☐ Talks excessively/doesn't wait for his/her turn

TASTE & SMELL:

☐ Has trouble eating different textured foods ☐ Insensitive to noxious smells/tastes ☐ Picky eater ☐ Prefers spicy, sour, or bitter food flavors ☐ Sensitive to noxious smells/tastes

VESTIBULAR (MOVEMENT):

☐ Gets carsick easily ☐ Likes rough housing, jumping, crashing games ☐ Loses balance easily ☐ Prefers to be sedentary (on computer/TV) rather than play outside

MUSCLE TONE:

☐ Gets tired easily playing or writing ☐ Seems generally weak compared to other kids ☐ Slouches when sitting on floor/chair

COORDINATION:

☐ Bumps into furniture/people often ☐ Cannot ride a bike ☐ Cannot tie shoelaces ☐ Does not enjoy sports ☐ Has an excessive number of accidents compared to other children ☐ Has difficulty holding a pencil or crayon in a 3-point position ☐ Has difficulty playing on playground equipment ☐ Has trouble using both hands together easily (e.g., opening milk carton, water bottle, etc.) ☐ Poor ball skills for P.E.-type activities ☐ Poor handwriting ☐ Seems clumsy/awkward ☐ Has difficulty with sequential tasks (e.g., dressing, buttoning)

Is the child:

- ☐ Right handed
- ☐ Left handed
- ☐ Mixed handed/ambidextrous

Is the child currently physically athletic or coordinated?

- ☐ No, poorly coordinated and not naturally good at most sports
- ☐ About average
- ☐ Yes, very coordinated and naturally athletic

Does the child currently have good fine motor coordination?

- ☐ No, poorly coordinated in fine motor activities
- ☐ About average
- ☐ Yes, very good with fine motor activities

Toileting

Please check off any of the following difficulties related to the child's toilet training:

- ☐ Bed wetting after training ☐ Nighttime soiling after training ☐ Soiling accidents during the day ☐ Urine accidents during the day

Please describe any of these difficulties, including frequency:

Comprehension and Understanding

Does the child understand directions and situations as well as other children his/her age?

- ☐ Yes
- ☐ No

If no, please explain:

If the child tells a story about a show, event, etc., do you or others have difficulty understanding him/her?

- ☐ Yes
- ☐ No

If yes, is it because s/he (check all that apply):

- ☐ Has trouble finding the right words
- ☐ Is confused
- ☐ Is disorganized
- ☐ Leaves out important information
- ☐ Loses train of thought
- ☐ Other, please describe:

Does the child (check all that apply):

- ☐ Have trouble remembering things s/he really cares about?
- ☐ Have difficulty following routines (bedtime, dressing, etc.)?
- ☐ Frequently lose things or have trouble being organized?

If yes to any of the above, please describe:

How would you rate the child's overall level of intelligence compared to other children?

- ☐ Below average
- ☐ Average
- ☐ Above average

Do you have any comments about the child's (check all that apply):

- ☐ Sexual knowledge or awareness
- ☐ Gender identity
- ☐ Sexual orientation

If yes to any of the above, please describe:

Environmental Exposures

Has the child ever lived near a refinery, polluted area, or in a home with lead paint?

- ☐ Yes
- ☐ No

If yes, please describe:

Has the child ever lived in a house that had new carpeting, paint, cabinets, or any other refurbishing that seemed to affect the child's health?

- ☐ Yes
- ☐ No

Does the child seem particularly sensitive to perfumes, gasoline, or other vapors?

- ☐ Yes
- ☐ No

What year was the child's home/apartment built? (if you don't know, skip to the next question)

Does the child live in a home with vinyl blinds?

- ☐ Yes
- ☐ No

If yes, what year were they put in? (if you don't know, skip to the next question)

From where does the child's home get water?

- ☐ City
- ☐ Well
- ☐ Other
- ☐ Don't know

If other, please specify:

Primary type of heat in the child's home:

- ☐ Gas
☐ Electric
☐ Heating Oil
☐ Wood Stove
☐ Other
☐ Don't know

If other, please specify:

Does the child (check all that apply):

- ☐ live in a home around where pesticides, herbicides, or other chemicals are sprayed
☐ live a home with a water purification system
☐ live in a home with an air purifier
☐ live near high voltage power lines
☐ live near a refinery
☐ live near the woods
☐ live near an industrial area
☐ live near the water

If the child lives near water, what type of water is it?

- ☐ River
☐ Ocean
☐ Swamp
☐ Lake
☐ Other

If other, please specify:

Describe the child's bedroom (curtains, blinds, carpet, feather pillows, etc.):

Describe the flooring in other rooms the child spends time in at home:

Please note any important additional information regarding the child's developmental history:

Previous Section

Save for Later

Cancel

Next Section

Edit Comprehensive Child Clinical History Form (13 / 21)

Current Living Situation

How many people currently live in the child's household? (NOT including the child)

- Select One-

Please provide the following information for household/family members currently living in the child's home and for immediate family members currently living outside of the child's home:

Name	Is person living inside or outside of the home?	Person's relationship to the child	If the person is a family member, is he/she:	Gender	Age (in years, enter the number only; e.g., "43")	Grade/Job
<input type="text"/>	- Select One- <input type="text"/>	- Select One- <input type="text"/> If other, please specify: <input type="text"/>	- Select One- <input type="text"/> If other, please specify: <input type="text"/>	- Select One- <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	- Select One- <input type="text"/>	- Select One- <input type="text"/> If other, please specify: <input type="text"/>	- Select One- <input type="text"/> If other, please specify: <input type="text"/>	- Select One- <input type="text"/>	<input type="text"/>	<input type="text"/>

Please provide the following information about the child's biological parents:	Mother	Father
Name	<input type="text"/>	<input type="text"/>
Living or Deceased?	- Select One- <input type="button" value="v"/>	- Select One- <input type="button" value="v"/>
Age (current or when deceased); Please only list the number of years (for example, "44")	<input type="text"/>	<input type="text"/>
Birthplace	<input type="text"/>	<input type="text"/>
Occupation (current or previous)	<input type="text"/>	<input type="text"/>
Number of hours away from home per day. If not living in the home, leave blank.	<input type="text"/>	<input type="text"/>

What languages are spoken at home? If more than one, please indicate which language is primary within the home.

Please note any important additional information regarding the child's current living situation:

Previous Section
Save for Later
Cancel
Next Section

Edit Comprehensive Child Clinical History Form (14 / 21)

Family Relationships

Parental Relationships/Parenting

Are the child's parents currently:

☐ Together, but not living together or married
☐ Living together
☐ Married
☐ Separated
☐ Divorced
☐ Other

If other, please describe:

This has been the situation for the child's family/parents for how long? Please enter the years and months (e.g., 2 years and 3 months or 5 years)

If the child's parents are married, describe the current relationship, including any significant marital conflicts:

If the child's parents are separated or divorced, has "parent 1" remarried?

- Select One-

If yes, for how long has "parent 1" been remarried? Please enter the years and months (e.g., 2 years and 3 months or 5 years)

If the child's parents are separated or divorced, has "parent 2" remarried?

- Select One-

If yes, for how long has "parent 2" been remarried? Please enter the years and months (e.g., 2 years and 3 months or 5 years)

Please list any previous parental marriages/long-term relationships involving the child's parents:

If the child's parents are separated or divorced, is their relationship (check all that apply):

- ☐ No contact
☐ Minimal communication
☐ Amicable
☐ Conflictual
☐ High conflict (violence, no-contact order, etc.)

If the child's parents are separated or divorced, what are the current custody and visitation arrangements?

- ☐ The child lives with both parents
☐ Joint custody
☐ Other

If other, please describe:

If joint custody, please describe the arrangements:

Who is the child's primary caregiver?

Who cares for the child when the primary caregiver is away?

What are the current care arrangements for the child before and after school?

Who usually disciplines the child?

To what extent do the child's parents agree on parenting issues and discipline (if applicable)?

- ☐ Never Agree
☐ Rarely Agree
☐ Sometimes Agree
☐ Usually Agree
☐ Always Agree

Which of the following methods of discipline are used with the child (check all that apply): How effective is the method (usually):

<input type="checkbox"/> Loss of privileges	- Select One-
<input type="checkbox"/> Grounded from peers	- Select One-
<input type="checkbox"/> Grounded from cell phone	- Select One-
<input type="checkbox"/> Grounded from TV and/or computer	- Select One-
<input type="checkbox"/> Made to do extra chore(s)	- Select One-
<input type="checkbox"/> Spanking or other physical punishment	- Select One-
<input type="checkbox"/> Time out	- Select One-
<input type="checkbox"/> Reward chart	- Select One-
<input type="checkbox"/> Token economy	- Select One-
<input type="checkbox"/> Contingency management	- Select One-
<input type="checkbox"/> Other <input type="text"/>	- Select One-

Please explain how the child tends to respond to discipline:

Child's Relationships in the Family

Describe the child's relationship with his/her parents, noting if there is conflict and/or if the child has difficulty separating from the parent(s):

Describe the child's relationship with his/her siblings, noting if there is conflict:

Please check off the activities in which the child participates with the family (check all that apply):

☐ Movies ☐ Meals ☐ Conversations ☐ Visits with relatives ☐ Television ☐ Religious/spiritual activities ☐ Games ☐ Sports ☐ Trips ☐ Other

Please note any important additional information regarding the child's family relationships:

Previous Section

Save for Later

Cancel

Next Section

Educational History

How old was the child when s/he first attended school?

Were there any problems when the child first started school?

☐ Yes

☐ No

If yes, please describe:

Did the child (check all that apply):

☐ receive early intervention services or attend Head Start

☐ attend day care and/or preschool

☐ attend kindergarten

If yes to any of the above, please describe, including any problems and approximately how many hours per week (if applicable):

^
v

In the table below, please list all schools that the child has attended (NOT including the current school):

School Name	Grade(s) (e.g., "4th" or "6th-8th")	Year(s) (e.g., "2009" or "2012-2015")
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Name of the child's current school:

What grade is the child currently in? (e.g., "8th")

What year did the child start this school? (e.g., "2013")

School address:

School phone number:

School email:

School fax number:

Is this a:

☐ Public school

☐ Private school

☐ Other

If other, please describe:

In the next table, please indicate the child's academic performance per year in school:

	Failing	Below Average	Average	Above Average	Superior
Preschool	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kindergarten	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 6	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 8	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 9	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 10	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 11	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 12	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please describe any significant changes in the child's school performance over the years:

^

v

What are the child's current grades or GPA (if applicable)?

If there are poor grades, what do you see as the cause (check all that apply):

- ☐ Difficulty concentrating
- ☐ Not turning in completed work
- ☐ Not doing work
- ☐ Too anxious
- ☐ Learning disability
- ☐ Struggles with content
- ☐ Other

In the next table, please indicate the child's behavioral performance per year in school:

	Poor	Fair	Good	Excellent
Preschool	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kindergarten	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 6	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 8	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 9	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 10	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 11	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grade 12	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Has the child had any education-related testing or assessment?

☐ Yes

☐ No

If yes, what tests and what were the results?

^

v

Does the child have any known learning disabilities?

☐ Yes

☐ No

If yes, please describe:

^

v

Has the child ever (check all that apply):

☐ received support/services from the school

☐ received private support/special services

☐ been on an IEP or 504 plan

☐ participated in a gifted and talented program in school

If yes to any of the above, please describe (including age of the child, the reasons, and any notable changes):

^

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Has the child ever (check all that apply):

☐ had frequent school absences or missed an extended amount of school

☐ repeated a grade

☐ been suspended

☐ refused to go to school

If yes to any of the above, please provide details:

^

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Does the child like school?

- ☐ Yes
☐ No

Please describe the child's attitude towards school:

^

v

What are the child's MOST favorite subjects, sports, and/or activities? What does s/he excel at?

^

v

What are the child's LEAST favorite subjects, sports, and/or activities? What does s/he have the most difficulty with?

^

v

Please check any of the following that describe the child at school (check all that apply):

- ☐ Considered "bright but unmotivated" ☐ Daydreams ☐ Difficulties with peers ☐ Difficulty being quiet ☐ Difficulty following instructions
☐ Difficulty getting started on tasks ☐ Difficulty in groups ☐ Difficulty keeping hands to self ☐ Difficulty sitting still ☐ Difficulty staying focused during independent work ☐ Difficulty transitioning to a new task ☐ Distractibility ☐ Does not complete classroom work ☐ Does not do homework ☐ Does not remain seated ☐ Does not speak to peers at school ☐ Does not speak to teachers at school ☐ Excessive time to complete assignments ☐ Fails to check homework ☐ Frequently sent out of class ☐ Has a pattern of highly variable grades ☐ Has achieved less academically than parents or siblings (for age) ☐ Hyperactivity ☐ Impulsive ☐ Interferes with others' tasks ☐ Makes careless mistakes ☐ Meltdowns or tantrums ☐ Messy and disorganized ☐ Noncompliant in class ☐ Not wanting to go to school ☐ Oppositional with teachers ☐ Poor at math ☐ Poor at spelling ☐ Poor attention ☐ Poor handwriting ☐ Poor reader ☐ Requires additional supervision ☐ Skips school ☐ Talks inappropriately ☐ Test anxiety ☐ Too withdrawn or passive ☐ Upset when leaving parents ☐ Works too quickly ☐ Works too slowly ☐ Written language difficulties

Please note any important additional information regarding the child's educational history:

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Previous Section

Save for Later

Cancel

Next Section

Social History

Please describe the child's overall current social skills and peer relationships:

Please describe how you think the child interacts with peers while at school:

Would you describe the child's social support as:

- ☐ Poor
☐ Fair
☐ Good
☐ Excellent

Are you satisfied with the child's social situation?

- ☐ Yes
☐ No

Is the child satisfied with his/her social situation?

- ☐ Yes
☐ No

Does the child (check all that apply):

- ☐ have a best friend or friends ☐ have difficulty initiating activities with peers ☐ get into frequent conflicts/fights with peers ☐ have difficulty making friends ☐ have difficulty keeping friends ☐ have difficulty getting along with adults ☐ seem interested in having friends ☐ have friends that are a poor influence ☐ get invited to extracurricular activities (e.g., birthday parties, play dates) ☐ show an interest in getting to know other children when in a new setting (e.g., park, party) ☐ spend the night away from home

The child plays/interacts with children that are (check all that apply):

- ☐ the same age
☐ younger
☐ older

Does the child seem to miss social cues (e.g., not understanding when s/he is being teased, not understanding humor, not recognizing when children are disinterested in what s/he is talking about, perceives hostility when there is none)?

- ☐ Yes
☐ No

If yes, please describe:

Has the child been bullied/teased?

☐ Yes

☐ No

If yes, please describe:

^

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Has the child bullied other children or been aggressive in play with others?

☐ Yes

☐ No

If yes, please describe:

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v

Please note any important additional information regarding the child's social history:

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Previous Section

Save for Later

Cancel

Next Section

Edit Comprehensive Child Clinical History Form (17 / 21)

Lifestyle Health

Being as descriptive as possible, please describe the child - what is he/she like? Describe his/her temperament, strengths, and interests:

^

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Daily Living

Please select the best description of the child with respect to the following daily functions:

Needs a lot of help

Needs some help

Needs no help

Getting dressed

☐

☐

☐

Eating

☐

☐

☐

Bathing

☐

☐

☐

Getting food, etc.

☐

☐

☐

Chores/cleaning

☐

☐

☐

Sleep

What is the child's overall level of sleep quality?

- ☐ Poor
☐ Fair
☐ Good
☐ Excellent

How many hours of sleep does the child get during a typical night?

What time does the child usually go to sleep? Please enter in the following format: 00:00am/pm (for example, "7:30pm")

What time does the child usually wake up? Please enter in the following format: 00:00am/pm (for example, "8:30am")

Does the child have standard bedtime routines or rituals?

- ☐ Yes
☐ No

If yes, please describe:

Does the child sleep in the parents' room:

- ☐ Not at All
☐ Some of the Night
☐ All of the Night

If the child sleeps in the parents' room, please rate how concerned you are about this:

- ☐ Not at All
☐ Mildly
☐ Moderately
☐ Extremely

Please check off the following items that relate to the child's sleep:

☐ Bed wetting ☐ Bedtime behavior problems ☐ Can't sleep alone ☐ Chronic "night owl" ☐ Chronically tired from inadequate sleep ☐
Difficulty falling asleep ☐ Difficulty staying asleep ☐ Frequent waking ☐ Grinds teeth ☐ Naps during the day ☐ Nightmares ☐
Nighttime cough frequently ☐ Restless sleeping ☐ Sleep apnea ☐ Sleep walking ☐ Snoring ☐ Takes medicine in order to sleep ☐
Very heavy sleeper ☐ Very light sleeper ☐ Waking too early ☐ Other sleeping issues

If you selected "other sleep issues", please describe:

Describe any past or present concerns/difficulties regarding the child's sleep patterns:

Nutrition/Eating

Please indicate if the child has had recent significant weight change:

- ☐ Weight Loss
☐ Weight Gain
☐ Neither Weight Loss nor Weight Gain

If there was a recent significant weight change (loss or gain), how many pounds? (Please only enter the number of pounds; for example, "20")

Describe the child's appetite and diet:

Please check off the following items that relate to the child's diet/eating (check all that apply):

☐ Mostly baby foods ☐ Mostly meat ☐ Mostly carbohydrates (bread, pasta, etc.) ☐ Mostly vegetarian ☐ Mostly dairy (cheese, milk, yogurt) ☐ Eats too little ☐ Eats too much ☐ Excessively picky eater ☐ Strong aversion to eating textured foods ☐ Takes very long time to eat meals ☐ Other diet/eating issues

If you selected "other diet/eating issues", please describe:

Does the child have any food sensitivities/allergies?

- ☐ Yes
☐ No

If yes, please describe:

Has the child have tried any dietary modifications?

- ☐ Yes
☐ No

If yes, please describe (including the results):

Please describe the child's stool pattern, frequency, and consistency (e.g., daily, foul, large, mushy, brown):

Extracurricular Activities

Please describe how the child generally spends her/his free time (e.g., plays alone, plays with friends, plays sports, watches TV, plays video games):

What extracurricular activities, sports, and/or other special interests does the child engage in (inside or outside of school)? Also, please describe how well you feel the child does in these areas:

Please list any additional organizations, clubs, teams, or groups in which the child participates:

Does the child get regular exercise?

☐ Yes

☐ No

Please describe:

Please list the approximate number of hours per day that the child: (For each item below, please only list the number of hours; for example, "2")

Watches TV

Plays video games

Is on the computer

Is outdoors

Substances

To your knowledge, has the child ever used any of the following (check all that apply):	Never	In the Past (Suspected)	In the Past (Confirmed)	Current (Suspected)	Current (Confirmed)
Caffeine (frequent use only; in any form - including cola drinks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco (in any form)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription medication(s) to get high	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational drug(s) (including marijuana)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any, please list types and briefly describe the child's use of each (including frequency/amount):

Please note any important additional information regarding the child's lifestyle health:

Previous Section

Save for Later

Cancel

Next Section

Edit Comprehensive Child Clinical History Form (18 / 21)

Legal History

Has the child ever had any police contact or legal problems?

☐ Yes

☐ No

If yes, please describe:

Previous Section

Save for Later

Cancel

Next Section

Trauma/Stressors

Please indicate if the child has experienced any of the following significant events (check all that apply):	Date (month(s)) when this occurred (optional)	Date (year(s)) when this occurred	Age of child when this first occurred (years)	Age of child when this first occurred (months) (optional)
<input type="checkbox"/> Physical or emotional separations from caregivers	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Divorce of caregivers	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Death of family member(s) or other significant person(s)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Physical trauma/abuse	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Sexual trauma/abuse	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Emotional trauma/abuse	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Neglect	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Exposure to violence, drugs, or sexually explicit material	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> A significant move or moves	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> An accident	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Illness or injury	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Accident, illness, or injury of family member(s) or other significant person(s)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Family financial difficulties or job loss	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Other significant stressors in the family environment (including marital stressors)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Other <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If yes to any of the above, please briefly describe:

How does the child handle stress?

Please note any important additional information regarding trauma/stressors in the child's life:

Previous Section

Save for Later

Cancel

Next Section

Spiritual Orientation

Please describe the spiritual orientation or religion of the child's family:

How active are spiritual beliefs/religion in the family's life?

Not at all active

Somewhat active

Very active

Previous Section

Save for Later

Cancel

Next Section

Caregiver Comments

Please note any additional information about the child that you want to share:

Previous Section

Save for Later

Cancel

Submit