COMPREHENSIVE EARLY CHILDHOOD HISTORY FORM

Developed by:
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Child's Name: ______________________________ Date of Birth: ______________

Ethnicity/Cultural Identification: ________________ Gender: __________ Age: ________

Person Completing the Form: ________________ Relationship to Child: ______________

General Instructions

Dear Parents/Guardians:

As part of our work with this child, we ask that you fill out this form as fully and openly as possible. This information is helpful to ensure an accurate assessment, which will assist us in making appropriate recommendations. You may add or attach any additional information that you feel would be helpful in the evaluation process (e.g., past evaluation reports, report cards, etc.). We appreciate your cooperation and willingness to complete this form and to return it promptly to our office. When completing the forms, consider the following instructions:

1. Read the questions carefully and answer them in full.

2. Write as legibly as possible.

3. The child's parent/guardian should complete all forms. If parents/guardians wish to complete two separate packets, contact our office for an additional set of forms.

4. Please understand this information is for evaluation, intervention, and recommendation purposes. The information you provide *will* be part of the evaluation. If there are specific details that you are hesitant in sharing, contact our office for clarification or a private meeting.

Thank you in advance for completing this form.

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REFERRAL INFORMATION

Describe your concerns regarding this child (include details and dates when problems began).

Describe what you see as the cause of these difficulties.

Describe services or interventions you would like to see for this child.

Describe this child's strengths.

FAMILY INFORMATION

List the names and information requested for all individuals living in the household (include caregivers, siblings, stepparents, etc.).

Name	*Age*	*Relationship*	*Comments/Concerns*

Father/Guardian: ______________________ Age: ______ Education: ______________

Occupation: ______________________ Employer: ______________________

Mother/Guardian: ______________________ Age: ______ Education: ______________

Occupation: ______________________ Employer: ______________________

Parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Never married

Is this child living with both biological parents? ☐ Yes ☐ No

If no, explain: ____

If parents are separated or divorced, indicate the date and describe the present custody and visitation arrangements.

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Are there any siblings living outside the home? ☐ Yes ☐ No

If yes, list names, ages, and any concerns: ______________________________

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What is the primary language spoken at home? ______________________________

Does the family speak a second language? ☐ Yes ☐ No Language: ______________

If yes, circle child's proficiency: ☐ Fluent ☐ Limited ☐ Other

Check if there is a family history of any of the conditions or problems noted below.

Condition/Concern	*Mother*	*Father*	*Siblings*	*Other Relatives*
Learning or School-Related Problems				
Developmental Disability (e.g., MR, ASD)				
Attention Problems				
Behavior Problems				
Emotional Problems/Mental Health				
Substance Abuse/Addiction				
Medical Problems				

Provide explanation of any items checked above:

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List any agencies and/or caseworkers involved with this child or family (i.e., CYS, MH/MR, etc.).

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Describe any major stresses that have occurred in the family that may be affecting this child (e.g., death of family member, divorce, etc.).

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<u>DEVELOPMENTAL HISTORY</u>

Did this child's mother receive prenatal care? ☐ Yes ☐ No

Was the pregnancy with this child normal? ☐ Yes ☐ No

Check any of the following health complications that occurred during the pregnancy.

☐ Fever	☐ Vaginal bleeding	☐ Toxemia
☐ High blood pressure	☐ Gestational diabetes	☐ Trauma/injury
☐ Rash	☐ Emotional problems	☐ Abnormal weight gain
☐ Anemia	☐ Excessive swelling	☐ Excessive vomiting
☐ Blood incompatibility	☐ Preeclampsia	☐ Other:

Provide explanation of any items checked above: ______________________________

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Check any of the following used by the mother during the pregnancy.

☐ Prescription medication: (*list name and dose)* ______________________________

☐ Over-the-counter medications: (*list name and dose)* __________________________

☐ Illegal substances: (*list name and amount)* ________________________________

☐ Alcoholic beverages: (*list type and amount)* _______________________________

☐ Cigarettes: *Number of cigarettes per day:* ________________

Provide further information regarding pregnancy, as needed.

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What was the length of pregnancy? ____________ weeks

Was the labor and delivery normal? ☐ Yes ☐ No

If no, explain: ____

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The delivery was: ☐ Vaginal ☐ Cesarean (reason): ______________________________

Check any of the following complications that occurred during the delivery.

☐ Breech birth	☐ Cord around neck	☐ Meconium staining
☐ Lack of oxygen (turned blue)	☐ Forceps used	☐ Suction used
☐ Labor induced	☐ Medication for labor	☐ Cardiopulmonary distress
☐ Seizures	☐ Other:	☐ Other:

Provide explanation of any items checked above: ____

____

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Did the baby breathe spontaneously? ☐ Yes ☐ No

What was this child's birth weight? __________ Pounds __________ Ounces

How long was the baby's hospital stay? ______________ days

How long was the mother's hospital stay? ____________ days

Describe child's general behavior, eating, and sleeping as an infant and toddler.

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Indicate the age in which this child achieved the following milestones ***(estimate if unsure)***.

Sat alone: ____________________	Spoke first word: ____________________
Crawled: ____________________	Put 2-3 words together: ____________________
Stood alone: ____________________	Spoke in sentences: ____________________
Walked alone: ____________________	Learned alphabet: ____________________
Toilet trained: ____________________	Began to read: ____________________
Dry through Night: ____________________	Tied Shoes: ____________________

Indicate any of the following developmental concerns.

☐ Poor motor skills (describe): ____________________

☐ Oral motor problems (e.g., drooling, etc.) (describe): ____________________

☐ Speech delay/problems (describe): ____________________

☐ Problems with bedwetting (until what age?): ____________________

☐ Problems with daytime urine accidents (until what age?): ____________________

☐ Problems with soiling accidents (until what age?): ____________________

MEDICAL AND MENTAL HEALTH INFORMATION

How is this child's overall health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

List any serious illnesses, accidents, injuries, hospitalizations, surgeries or traumatic events.

Incident	*Date(s)*	*Provide Details*

Has this child's vision been checked? ☐ Yes ☐ No Any problems? ____________________

Has this child's hearing been checked? ☐ Yes ☐ No Any problems? ____________________

Date of last physical examination: ______________ By Whom: ____________________

Check any current or past concerns, provide a brief description.

Condition	*Occurrence*			*Provide Details for Each Checked*
Allergies	☐ Past	☐ Current	☐ Never	
Asthma	☐ Past	☐ Current	☐ Never	
Diabetes	☐ Past	☐ Current	☐ Never	
Failure to thrive	☐ Past	☐ Current	☐ Never	
Loss of consciousness	☐ Past	☐ Current	☐ Never	
High fevers	☐ Past	☐ Current	☐ Never	
Motor or vocal tics	☐ Past	☐ Current	☐ Never	
Lead poisoning	☐ Past	☐ Current	☐ Never	
Dizziness/blurred vision	☐ Past	☐ Current	☐ Never	
Stomach pain	☐ Past	☐ Current	☐ Never	
Constipation	☐ Past	☐ Current	☐ Never	

Frequent ear infections	☐ Past	☐ Current	☐ Never	
Ear tubes placed	☐ Past	☐ Current	☐ Never	
Staring spells	☐ Past	☐ Current	☐ Never	
Meningitis	☐ Past	☐ Current	☐ Never	
Encephalitis	☐ Past	☐ Current	☐ Never	
Epilepsy/Seizures	☐ Past	☐ Current	☐ Never	
Exposure to toxin	☐ Past	☐ Current	☐ Never	
Head banging	☐ Past	☐ Current	☐ Never	
Excessive vomiting	☐ Past	☐ Current	☐ Never	
Eating problems	☐ Past	☐ Current	☐ Never	
Self-injurious behavior	☐ Past	☐ Current	☐ Never	
Repetitive movements	☐ Past	☐ Current	☐ Never	
Impulsivity	☐ Past	☐ Current	☐ Never	
Clumsiness/Accident prone	☐ Past	☐ Current	☐ Never	
Rocks back and forth	☐ Past	☐ Current	☐ Never	
Under-eating/Over-eating	☐ Past	☐ Current	☐ Never	
Eating nonfood items	☐ Past	☐ Current	☐ Never	
Traumatic brain injury	☐ Past	☐ Current	☐ Never	
Other: ___________________	☐ Past	☐ Current	☐ Never	

List any medications this child takes on a regular basis.

Medication	*Dosage/ Frequency*	*Purpose*	*Side Effects*

Check all of the following evaluations that have occurred in the part and provide requested details.

Previous Evaluations	*Date(s)*	*Provider*	*Reason and Outcome/Diagnosis*
☐ Psychological			
☐ Psychiatric			
☐ Speech/Language			
☐ Neurological			
☐ Other: _______________			

Has this child ever experienced or been witness to any traumatic events? ☐ Yes ☐ No

If yes, explain: ______________________________

List any mental health/behavioral treatment received (e.g., inpatient, outpatient, substance, etc.):

Dates of Service	*Provider*	*Reason*	*Outcome*

Provide any additional information regarding this child's medical or mental health background:

EDUCATIONAL INFORMATION

Did/Does this child receive Early Intervention Programming? ☐ Yes ☐ No

If yes, explain: ______________________________

List all preschools/daycares this child has attended:

Preschool/Daycare	*Location*	*Comments/Problems*

What has the preschool teacher told you about this child's performance in preschool?

SOCIAL INTERACTIONS

Does this child have difficulty relating to or playing with other children? ☐ Yes ☐ No

Does this child have difficulty making and keeping friends? ☐ Yes ☐ No

Does this child have difficulty understanding social cues? ☐ Yes ☐ No

If you checked yes for any of the above questions, describe your response:

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____

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ADDITIONAL INFORMATION

Provide information on this child's interests.

____

List any activities this child dislikes.

____

What types of discipline are used with this child at home (indicate effectiveness)?

____

____

Provide information on the following self-help skills.

Adaptive Behavior	*Child's Functioning*		*Provide Details of Rating*
Communication	☐ Below Average	☐ Age Appropriate	
Changing clothes	☐ Below Average	☐ Age Appropriate	
Brushing teeth	☐ Below Average	☐ Age Appropriate	
Washing self	☐ Below Average	☐ Age Appropriate	
Feeding self	☐ Below Average	☐ Age Appropriate	
Using toilet	☐ Below Average	☐ Age Appropriate	
Playing with others	☐ Below Average	☐ Age Appropriate	
Cleaning up toys	☐ Below Average	☐ Age Appropriate	
Asking for help	☐ Below Average	☐ Age Appropriate	
Controlling emotions	☐ Below Average	☐ Age Appropriate	

Write any additional comments regarding this child that may assist in this evaluation.

Signature of Parent/Guardian: ______________________ Date: ____________

Relationship to child: ______________________