Hunterdon Health

ABBREVIATED
CHILD HISTORY FORM

Child's Full Legal Name: _____

Address: _____ Phone #_____

City: _____ State _____ Zip: _____County: _____

Child's SS#: _____ Sex: M F Birth Date: _____

School/District: _____ Phone #: _____

Grade: _____ Parent Email Address _____

Parent A – Biological Adoptive Step Foster (circle one)

Name: _____ Date of Birth _____ Social Security # _____

Home Phone #:_____ Work Phone # _____ Cell Phone # _____

Address if different from above: _____

Employed: FT PT Retired Unemployed (circle one) Occupation: _____

Highest Level of Education _____

Health - Excellent Good Fair (circle one) Marital Status: _____ Sex _____

Learning, Attention or Emotional problems? Please describe: _____

Parent B – Biological Adoptive Step (circle one):

Name: _____ Date of Birth _____ Social Security # _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Address if different from above: _____

Employed: FT PT Retired Unemployed (circle one) Occupation:_____

Highest Level of Education: _____

Health – Excellent Good Fair (circle one) Marital Status: _____ Sex_____

Learning, Attention or Emotional problems? Please describe: _____

Referral Information

Who referred you to our services? _____

Why are you seeking help for this child? _____

_____

_____

_____

Primary Care Physician: (Please enter **physician name** not the practice name)

_____

PCP Address: _____

PCP Phone # _____ Date of Last Visit: _____

How often does this child see a doctor? _____

Race (Please circle any that apply)

White
Black/African American
Asian Indian
Other Asian
Hispanic
Japanese
Vietnamese
Native Hawaiian
Chinese
Korean
Filipino
Native American
Other Pacific Islander
Other
Unknown

Ethnicity (Please circle any that apply)

Non Hispanic
Central or South American
Mexican/ Mexican American
Puerto Rican
Other Spanish/Hispanic
Unknown

What is the primary language spoken at home? _____

Secondary language(s) ? _____

Name of person answering this form: _____

Relationship to this child: _____

With whom does the child live with? _____

How long in current living situation? _____

Preferred Contact Person _____

Has your child ever experienced any parental separations, divorces, or deaths? _____

If yes, how old was your child at the time and please describe the circumstances _____

_____

If parents are separated or divorced, who has **Primary Custody** of your child? _____

Is there a custody agreement? _____

How often does your child see the non-custodial parent? _____

Who cares for this child when the caregivers are gone? _____

How many different people care for this child? _____

How many hours per day is the child in a child-care setting? _____

Please explain: _____

Siblings and Relatives

Please list all brothers and sisters and any other person living with the family

Name	Age	Relationship To Child	Living At Home?	Learning Problems	Emotional Problems?	Developmental Disabilities	Physical Disabilities?	Date Of Birth

Please list any other Family Members with a history of learning or developmental disorders, attention issues, or psychiatric/psychological problems.
For example: Maternal grandmother has been anxious for years.

Name	Description

Is there a Family History of: Cardiac Disease __Y __N, Cancer __Y __N

Child's Medical History

(Please circle all that apply)

GASTROINTESTINAL

Excessive vomiting Frequent Diarrhea Constipation Chronic Abdominal Pain

MUSCULOSKELETAL

Muscle Pain Clumsy Walk Poor Posture Scoliosis Other Muscle Problems

RESPIRATORY

Frequent Colds Asthma Hay Fever

(Please circle any that apply)

HEARING

Ear Infections Hearing Problems Ear Tubes Date of most recent Hearing Exam _____

VISION

Vision Problems Wears Glasses Date of most recent Vision Exam _____

CARDIOVASCULAR

Shortness of Breath or Dizziness with Exertion Activity Limitation Due to Hear Condition

Heart Murmur Anemia

NEURO

Seizures Chronic Headaches Encephalitis/Meningitis Verbal/Motor Tics

Head Injury Loss of Consciousness High Lead Levels

ALLERGIES

Allergies other than Food Allergies

SKIN

Birthmarks

IMMUNIZATION

Current – Yes/No If not, please explain reason _____

MEDICATIONS

Please list all **LONG-TERM** medications this child has ever been on:

AGE	MEDICATION	DOSAGE/STRENGTH	HOW LONG ON MEDICATION
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____

Please list any **CURRENT MEDICATIONS** prescribed or OTC/supplements

MEDICATION	DOSAGE/STRENGTH	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ANY HOSPITALIZATIONS OR EMERGENCY ROOM VISITS

Year _____ Reason _____

Year _____ Reason _____

Year _____ Reason _____

PLEASE LIST ANY MEDICAL SPECIALIST THAT YOUR CHILD HAS SEEN IN THE PAST OR IS PRESENTLY SEEING

_____

_____

_____

_____

PLEASE INDICATE ANY TESTING YOUR CHILD HAS HAD
(Please circle all that apply)

Hearing MRI EEG CT Scan Lead Thyroid

Other Testing not listed _____

DEVELOPMENTAL and BEHAVIORAL HISTORY

Which Hand does your child use for:

Writing or Drawing _____ Has your child been forced to change writing hand? Y/N

Eating _____ Which foot does your child kick with _____

Other (throwing, ect.) _____

Does your child have Poor Handwriting Y/N

Does your child have Speech/Language deficits Y/N

What do you enjoy most about this child? _____

What do you find most difficult about raising this child? _____

How old do you think your child acts? _____

What makes your child angry? _____

Please describe discipline techniques: _____

Describe your child's Activity Level _____

Does your child have mood swings? If yes, how often? _____

Does your child exhibit any of the following behaviors? (Please circle any that apply)

Accident Prone Short Attention Span Lacks Self-Control Requires a lot of Parental Attention

Sucks Thumb Grinds Teeth Nail Biting Flaps Hands when Excited Rocks Back & Forth/Sideways

Withholds Affection Bangs Head Trouble Separating from Parents

Toe Walks Has Poor Eye Contact Uncomfortable with New People Has Fears

Seems Unhappy Seems Anxious Excessive Crying Temper Tantrums

Does your child have problems relating to or playing with other children? Y/N (if yes circle all that apply):

Fights frequently with playmates Prefers playing with younger children

Has difficulty making friends Prefers to play alone

Other, please describe: _____

What activities does your child enjoy?

Sports: _____ Hobbies _____

Other: _____

Has your child's interest in participating in these activities declined recently?

If yes please describe: _____

SLEEP HABITS

What time does your child go to bed? _____

What time does your child fall asleep? _____

(Please circle all that apply):

Night Awakenings Yes/ No If Yes how often _____

Restless Sleeper Night Terrors Sleep Walking Sleep Talking Snoring

EATING HABITS

(Please circle all that apply):

Picky Eater – Please Describe _____

Special Diet Food Allergies

Does this Child sit for meals? _____

SENSORY ISSUES

(Please circle all that apply):

Intolerance to:

Certain Noises/Sounds Dirty Hands Haircuts Odors Food Textures/Temperature

Clothing Tags/Fabrics

EDUCATIONAL

Is your child currently classified? _____
If yes, please include a current copy of the IEP or 504 plan when returning completed paperwork.

Is this child in a self-contained special class? _____

How many students are in the class? _____

How many teachers are in the class? _____ Special Education teacher? Y / N Mainstream teacher? Y / N

Does your child receive academic support and if yes please describe type of support and subjects:

_____

_____

Does your child receive academic tutoring and if yes please list subjects _____

_____

What are your child's best subject areas and average report card grade in these subjects? _____

_____

_____

What are your child's worst subject areas and average report card grad in these subjects? _____

_____

_____

Are you satisfied with your child's current educational program Y / N

If not, why? _____
Has your child ever repeated a grade? Y / N _____

SCHOOLS ATTENDED

Early Intervention: 0 to 3 Y / N

County:_____ Service Coordinator: _____

Please list services received: _____

If currently receiving Early Intervention services please include copies of ISFP and Battelle test with your completed paperwork

Preschool

Name of School _____

What age? _____ How many hours per day? _____ How many days per week? _____

Please list any services received: _____

_____

Please describe any problems experienced in Preschool: _____

_____

Kindergarten

Name of School _____

What age? _____ How many hours per day? _____ How many days per week? _____

Please describe any problems in Kindergarten: _____

_____

Elementary

Name of School _____

Grades attended _____

Please describe any problems _____

_____

Please list any services and or supports received: _____

_____

Middle School

Name of School _____

Grades attended _____

Please describe any problems _____

_____

Please list any services and or supports received: _____

_____

High School

Name of School _____

Grades attended _____

Please describe any problems _____

_____

Please list any services and or supports received: _____

_____

ADDITIONAL COMMENTS:

_____

_____

_____

_____