CHILD'S HISTORY

In order for our professionals to serve you better, please answer the following questions and return this form prior to your appointment, or you may bring it in with you. Feel free to add any extra comments on a separate sheet. If there are any questions you cannot, or choose not to answer, please leave them blank.

Today's date Name of child
Birthdate School Grade Teacher
Your name and relationship to child
Name of child's legal guardian(s)
Who referred you to Dr. Bransford?

CONCERNS

What are the main concerns you have about your child?

A. How long has this problem been a concern?
B. When did you first notice the problem?
C. Who else have you seen for this problem?
D. What evaluations have already been performed?

E. What has already been done to treat this problem (diet, medications, counseling)?

F. What have you done, personally, to address the problem?

G. What seems to help the most?

PREGNANCY AND BIRTH

1. Was the pregnancy a) planned? Yes ___ No ___
   b) welcomed? Yes ___ No ___
   c) stressful? Yes ___ No ___
2. How many weeks into the pregnancy was it diagnosed?
3. For the three months prior to the pregnancy and the first two months of pregnancy did the mother use any:
   prescribed medications? Yes ___ No ___ How much
   recreational drugs? Yes ___ No ___ How much
   alcohol? Yes ___ No ___ How much
   tobacco? Yes ___ No ___ How much
4. During the following seven months of pregnancy did the mother use any:
   prescribed medications? Yes ___ No ___ How much
   recreational drugs? Yes ___ No ___ How much
   alcohol? Yes ___ No ___ How much
   tobacco? Yes ___ No ___ How much
5. Where there any medical concerns or other issues during the pregnancy regarding the mother and /or the baby?

6. In what hospital was the child born?
   Address
7. Please list types of pain medications/anesthesia used during delivery

8. At the time of birth:
   How long did the pregnancy last? _____ weeks
   How long was the labor? _____ hours
   What was the baby's birth weight? _____ lbs _____oz, length _____ inches
      Head circumference? _____ inches
   Was the baby born vaginally ___ or Caesarean ___
   Was the baby born heard first ___ breech ___ or other (explain)
   Did the baby have? (Please circle all that apply)

trouble breathing	yellow jaundice	blood transfusion
resuscitation	jitteriness	physical injuries
twin	seizures/fits	trouble sucking
birth defects	cord around neck	intensive care
fevers or low temperature		

9. Was the baby breast fed? _____ How long? ___ months Bottle fed? _____ Formula name
10. Did the baby have any early feeding problem? _____ Describe
11. Were there any other concerns or problems noted by either the doctors or parents? Please describe

12. Is your child adopted? _____ Does he/she know? _____ If not, do you intend to tell him/her? _____

HEALTH

1. Has your child had any of the following? (Please circle all that apply):

measles	mumps	chicken pox	whooping cough
pneumonia	encephalitis	meningitis	ear infections
lead poisoning	allergies	vision problem	hearing problems
unexplained high fevers			

   Please explain any you have circled

2. Does your child have any of the following? (Please circle all that apply):
   A. sleep problems (falling asleep, staying asleep, nightmares, sleepwalking, etc.)
   B. brain disorders (headaches, seizures, motor or vocal tics, tremors, confusion, muscle weakness, coordination difficulties, head injury, staring spells, unexplained anger or sudden and unprovoked emotional outbursts, etc.)
   C. lung problems (shortness of breath, asthma, coughing, etc.)
   D. skin disorders (acne, hair loss, birthmarks, dermatitis, eczema, etc.)
   E. blood disorders (anemia, bleeding bruising, etc.)
   F. heart problems (chest pain, surgery, congenital heart disease, murmur, etc.)

G. sexual problems (birth control, promiscuity, excessive masturbation, etc.)
H. kidney problems (bedwetting, infections, etc.)
I. muscle or bone problems (scoliosis, injuries, strains, spasticity, etc.)
J. history of poisoning (lead, chemicals, others)
K. gland problems (obesity, slow or fast growth, early or delayed puberty, thyroid problems, etc.)
L. stomach or bowel problems (diarrhea, vomiting, constipation, stomach aches, stool soiling, etc.)
M. genetic disorders (birth defects, inherited traits, chromosome abnormalities, etc.)

Please explain any of the items which you have circled

3. Has your child ever been hospitalized? If so, explain each hospitalization, including ages, reasons and length of stay

4. Has your child ever taken medication to help with behavior or emotional problems?

Age	Medicine	Doctor	Reason	When/why stopped?

5. Does your child take ANY medication on a regular basis for chronic or recurring conditions? (Due to drug interactions, please list <u>all</u> medications.)

Medicine	Doctor	Reason	Start date

6. Has your child had any special diagnostic tests? (X-rays, EEG, MRI, CT scan, blood tests, etc.)

Age	Test	Reason	Result

7. Have you ever suspected that this child might have been physically or sexually abused? Yes ___ No ___
If yes, please explain:

DEVELOPMENT

1. Early development

A. At about what age did your child first:	Age	Early	On Time	Late
Smile, goo and coo?	_____	_____	_____	_____
Sit up?	_____	_____	_____	_____
Crawl?	_____	_____	_____	_____

Stand alone?	_____	_____	_____	_____
Speak real words?	_____	_____	_____	_____
Walk by self?	_____	_____	_____	_____
Feed self?	_____	_____	_____	_____
Use two word sentences?	_____	_____	_____	_____
Dress self (except buttoning and tying)?	_____	_____	_____	_____
Speak so that strangers understood?	_____	_____	_____	_____
Ride a tricycle?	_____	_____	_____	_____
Ride a bicycle?	_____	_____	_____	_____
Tie own shoes?	_____	_____	_____	_____

B. Do have any concerns about your child's motor or muscle development?

C. Do any of the following concern you regarding your child's language development? (Please circle)

trouble finding the right word	too few words
unconnected thoughts	repeats words/phrases over and over
has seen a speech therapist	speech clarity
following directions	seems confused when spoken to
stuttering	missing sounds (like r or k)

D. Have you ever been concerned or been told that your child's development (speech and language, coordination, growth or social abilities) was behind his/her peers?

E. Did your child seem to learn pre-academic skills, such as numbers, colors, shapes, etc., at the same time as other children his/her age? If not, please explain:

SCHOOL

1. What is your impression of your child's learning potential? (Please circle)

   Low average above average gifted

2. Do you feel that your child is performing up to his/her potential in school? Yes ___ No ___
3. Do you feel that your child has any difficulties with (circle any that apply and explain):

   reading
   writing
   arithmetic
   social studies
   science
   languages

4. Is homework a problem? (Please circle all that apply):

can't get started	no place to work
forgets to bring home materials	forgets assignments
doesn't understand the work	doesn't anticipate deadlines

distracted by radio, TV or anything	takes too long		
battles or argues about doing work	the most stressful time of the day		
needs you there constantly	doesn't care/no motivation		

5. Is your child's work made more difficult by problems with:	Not at all	Somewhat	A lot
poor concentration	___	___	___
giving up too easily	___	___	___
inconsistent performance	___	___	___
poor motivation	___	___	___
disorganization	___	___	___
spacing out or daydreaming	___	___	___
not finishing things	___	___	___
having low frustration tolerance	___	___	___
poor handwriting	___	___	___
rapidly shifting from one thing to another	___	___	___
being easily distracted	___	___	___
impulsiveness	___	___	___

6. Has your child ever been? retained ___ suspended ___ expelled ___ advanced a grade ___

SOCIAL

Does your child get along well with others? In what areas do you notice difficulties? Please answer **yes**, **no** or **sometimes** to the following. You may add comments.

makes friends easily
has a best friend
plays well with others
shares easily
follows rules
enjoys team sports
leads other children
helps others
easily influenced
prefers to be alone
is a party animal
bullies others
fights others
insists on having his/her own way

SELF-ESTEEM

Does your child:			
have an "I can do it" attitude?	Yes ___ No ___	give up easily?	Yes ___ No ___
recover from upsets?	Yes ___ No ___	stand up for self?	Yes ___ No ___
recognize strengths?	Yes ___ No ___	lack confidence?	Yes ___ No ___
		act adventuresome?	Yes ___ No ___

FAMILY

1. Are you satisfied with how your family works? (Please circle any that might apply):

lack of structure; rules	no family "together times"

poor communication
poor division of chores, responsibilities
marital problems
financial troubles
lack of "breathing space"
resentment of another member

Comments

2. Where and how does this child fit in the family? (Please circle any that apply):

sibling rivalry (more than expected)
spoiled, always get own way
a rescuer, can't stand upsets
a team player
a manipulator
a helper

Born baby # ___ out of ___ children

3. What types of discipline are used in your family? Use **M** to indicate which ones mother uses, **F** to indicate which ones father uses:

discussion and education
encouraging independent thinking
contracts/token systems
lecturing, nagging, yelling
positive reward and praise
time out
spanking
restriction/grounding

4. Please circle any of the following stressors which might apply to your family's situation, or to which the child had an extremely strong reaction. Please note how long ago the stressor occurred:

Parental separation/divorce
Death of a family member/important friend
Change in school
Financial stress
severe illness
move to a new house
change of job
pregnancy/birth of new child

Comments

5. Are there any "family secrets" or important things we have left out? Please include such things as relationships between divorced parents, involvement in extended family, parental adjustment difficulties, etc.:

6. Please circle current marital status: married single divorced widowed live together

7. If divorced from biological parent, what are the custody arrangements (legal and physical, please)?

8. If divorced, what is the non-custodial parent's involvement with this evaluation?

9. What are the names, ages and relationships of other children living at the home?

10. Is there any family history of medical, developmental, learning, psychiatric or legal difficulties?

Yes ___ No ___ If yes, please list the individuals relationship to the child, the nature of each difficulty, and any treatments received. Please include past generations and extended family if you have such information:

11. Please describe any psychiatric or psychological treatment this child or any sibling has received:

12. Please review each of the following lists of characteristics and check any item that applies to your child:

A. Does your child have any of the follow attention related troubles?

___ fidgets
___ easily distracted
___ difficulty play quietly
___ shifts from one activity to another
___ often interrupts or intrudes on others
___ often engages in physically dangerous activities
___ often blurts out answer to questions before competed
___ difficulty remaining seated
___ difficulty awaiting turn
___ difficulty sustaining attention
___ often does not listen
___ often loses things
___ difficulty following instructions
___ often talks excessively

B. Does your child have any of the following oppositional troubles?

___ often deliberately acts to annoy others
___ is often touchy or annoyed by others
___ often swears/uses obscene language
___ often blames others for own mistakes
___ often actively defies or refuses adult requests of rules
___ often takes or touches others' property without asking
___ often argues with adults
___ is often angry or resentful
___ is often spiteful or vindictive
___ often loses temper

C. Has your child had problems with any of the following?

___ stolen without confrontation
___ deliberate fire setting
___ breaking and entering
___ cruel to animals
___ forced someone else into sexual activity
___ often initiates physical fights
___ lies often
___ often truant from school
___ destroyed others' property
___ used a weapon in a fight
___ stolen with confrontation
___ physically cruel to people

D. Does your child show any of the following anxiety symptoms?

___ unrealistic worry about future events
___ persistent refusal to go to school
___ bothersome thoughts
___ unrealistic concerns about competence
___ repeated nightmares about separation from you
___ excessive distress when separated from home or from you
___ avoidance of being alone
___ physical aches and pains
___ marked self consciousness
___ marked inability to relax
___ ongoing refusal to sleep alone
___ excessive need for reassurance

___ unrealistic and persistent worry that something will happen to you

E. Does your child show?

___ diminished pleasure in activities
___ depressed
___ irritable mood most of the day
___ poor appetite
___ overeating
___ trouble sleeping
___ sleeping too much
___ feelings of worthlessness
___ excessive inappropriate guilt
___ difficulty making decisions
___ suicidal thoughts
___ suicidal actions
___ agitation
___ sluggishness
___ low self esteem
___ low energy
___ fatigue
___ feelings of hopelessness
___ poor concentration

F. Does your child have any of the following?

___ repeated unusual movements
___ compulsive rituals
___ vocal tics
___ excessive reaction to noise
___ odd postures
___ motor tics
___ overreacts to touch
___ failing to react to loud noises

G. Has your child exhibited any symptoms of thought disturbance, including any of the following?

___ can't get to the point, loses train of thought
___ bizarre ideas (odd fascinations, strange ideas, hallucinations)
___ disoriented, confused, staring or "spacey"
___ incoherent speech (mumbles, uses words only the child understands)

H. Has your child exhibited any symptoms of affective mood disturbance, including any of the following?

___ explosive temper with little provocation
___ excessively monotonous or bland affect
___ situationally inappropriate emotions
___ excessive reaction to changes in routine
___ unusual fears
___ panic attacks
___ excessive mood swings

Comments regarding any of the above items which you checked:

STRENGTHS

Please tell us about your child's most outstanding characteristic, hobbies, achievements, abilities, etc.:

Thank you for taking the time to complete this questionnaire. We know it is long and time consuming, but it really helps us to serve you and your child better. If you can return it to us prior to your visit, we will review

what you have shared with us in order to better focus on your concerns. This inform is strictly confidential. It will not be released to anyone without your written permission.