ICARD PLLC

Children's History Information Form

Date:			
Child's Name:	Gender:	Date of Birth:	Age:
Mailing Address:	City:	State:	Zip:
Residing Address:	City:	State:	Zip:
Home Phone: ( )	Cell: ( )	Work: ( )	
E-mail Address:			
Name of person filling out this form:			
Relationship to Child:			
Parent's Name (Mother):			Age:
Occupation (Mother):		Business Phone:	
Parent's Name (Father):			Age:
Occupation (Father):		Business Phone:	
Parent's Name (Co-parent):			Age:
Occupation (Co-parent):		Business Phone:	
Parents marital status: circle one Single Married Partnered Living Together Separated Divorced			
If parents are divorced, who has legal custody?			
Is child in foster care? Yes No	If yes, caregiver's name:		
Is child adopted? Yes No If yes, when?		Age at adoption:	
Referred By:			
Reason for Referral:			
Primary Care Provider (PCP):		Phone:	
Address:			
City:	State:	Zip:	
School Currently Attending:		Grade:	
Child's Teacher (s):			
IEP Yes No Current? Yes No	504 Plan Yes No Current? Yes No		
Eligibility category for IEP:	Disability for 504:		

ICARD, PLLC
701 W. 7th Avenue, Suite 130, Spokane, WA 99204 (509) 838-3932 Fax (509) 838-1163

Family Information: Please change or add titles as needed to accommodate your family's composition

	Indicate Below: Biological = B Adoptive = A Foster = F Step = S	Age	Occupation	City of Residence	Quality of Relationship with Patient/ Comments
Mother 's Name:					
Father 's Name					
Mother's Name					
Father's Name					
Other (Grandparent, Co parent, Guardian)					
Other (Grandparent, Co parent, Guardian)					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					
If Applicable: Child of their own					

Prenatal and Birth History

Mother's general health during pregnancy (illnesses, accidents, medications, etc.):			
Length of pregnancy: Weeks	Length of Labor: _____Hours	Birth weight: ____lbs. _____oz.	
Circle type of delivery: Normal	Instrument	Breech	Caesarian
Were there any unusual conditions that may have affected the pregnancy or birth?			

Medical History

Provide the approximate ages at which the child suffered the following illnesses and conditions:

	Age		Age		Age
Allergies		Asthma		Chicken Pox	
Ear Infections		Encephalitis		Headaches	
Head Injury		High Fever		Influenza	
Measles		Meningitis		Mumps	
Pneumonia		Seizures/Convulsions		Sinusitis	
Tonsillitis		Whooping Cough/Croup		Other	

Surgeries:
Injuries:

List any medications your child has taken in the past for more than a month (include dosage given and reason it was taken):
List any medications your child is currently taking (include dosage given and reason for taking it):
List any visual concerns/issues:
List any hearing concerns/issues:
Date of last hearing screening:
List any special medical tests (give name, date, and results i.e., EEG):
Have you consulted any medical specialists or psychological testing for your child? Yes ____ No ____

Who?	When?
Reason:	
Results:	

Developmental History

Provide the approximate age at which the child began to do the following activities:

	Age		Age
Turn over		Dress self	
Sit alone		Show interest in or attraction to sound	
Crawl		Understand first words	
Stand alone		Speak first words	
Feed self		Put 2-3 words together	

Was child breast-fed? Yes ___ No___	Was child bottle-fed? Yes___ No___
Any issues around feeding?	
Age when child was toilet trained? Days:	Nights:
Bed-wetting after toilet training? Yes___ No___ If yes, until what age?	
Bed soiling after toilet training? Yes___ No___ If yes, until what age?	
Any medical reasons for bed wetting/soiling? Yes___ No___ If yes, please describe	

Any problems with the following (Circle yes or no, if yes please describe):

Problem			If yes, please describe
Walking difficulty	No	Yes	
Unclear speech	No	Yes	
Feeding Problem	No	Yes	
Failure to Thrive	No	Yes	
Colic	No	Yes	
Overweight	No	Yes	
Underweight	No	Yes	
Sleep problem	No	Yes	
Eating Disorder	No	Yes	
Excessive crying	No	Yes	
Separating from parents	No	Yes	
Temper tantrums	No	Yes	
Difficulty w/motor skills	No	Yes	
Other:			
Other:			

Behavior and Social History

Who lives in the home?
Are there significant marital/relational conflicts? Yes____ No____
Are there significant conflicts between child and parent? Yes____ No____
Do parents agree on how to discipline child? Yes ___ No____
Who disciplines and how?
What does your child do when you discipline him/her?
Does your child have difficulty getting along with children his/her own age? Yes____ No____
Does your child have difficulty getting along with adults? Yes____ No____
How does your child prefer to occupy him/herself?

Check (√) the ones that currently describe your child:

Well behaved		Immature	
Clumsy using hands		Clumsy in walking	
More active than other children		Athletic	

Does your child or did your child ever have:

Blank spells		Poor handwriting	
Breath holding spells		Sleep problems	
Eat paint, paper, etc.		Tics or twitching	
Falling spells		Toe walking	
Head banging		Difficulty with attention to a task	

Which hand does your child prefer?. Right_____ Left_____ Age established _____
Does your child switch hands to write, eat, etc? Yes_____ No_____
Has your child had emotional, adjustment, or behavioral problems? Yes_____ No_____
Circle the term(s) that best describes your child's mood most of the time: Happy Sad Withdrawn Fearful Irritable
Counseling: Has your child received any counseling? Yes_____ No_____
If yes, by whom? Duration?
Was it helpful and/or what recommendations were made?

Have you consulted with anyone else for the current problems? Yes____ No_____	
Who?	When?
Results/Recommendations?	

School History

Did your child attend a nursery school or a preschool program?.....Yes____ No____ Age started ____
Were there problems?....Yes____ No____ If yes, describe

Has the school currently reported problems with the following (Circle Yes or No):

Arithmetic	Yes	No	Attention span	Yes	No
Reading	Yes	No	Behavior	Yes	No
Spelling	Yes	No	Social adjustment	Yes	No
Writing	Yes	No	Following directions	Yes	No
Organization	Yes	No	Emotional control	Yes	No

Does your child like school? Yes____ No____	
Is your child in a special education class or receive any special services in school (resource room, tutoring, remedial reading, speech/language therapy, occupational therapy, etc.)?. Yes____ No____	
If yes, what kind?	
When was (s)he placed there?	
Have you gotten any tutoring help privately for your child? Yes____ No____	
By whom?	
When?	How often?

Did anyone in your immediate family or other relatives have any of the following?
(If so, who? Parents, maternal or paternal grandparents, aunts, uncles, brothers, sisters, cousins, etc.):

Addiction	Yes	No	Who?
Alcoholism	Yes	No	Who?
Anxiety or OCD	Yes	No	Who?
Asthma	Yes	No	Who?
Autism Spectrum Disorder (or Asperger's)	Yes	No	Who?
Depression	Yes	No	Who?
Diabetes	Yes	No	Who?
Emotional Problems	Yes	No	Who?
Headaches or Migraines	Yes	No	Who?
Hearing problems (not due to aging)	Yes	No	Who?
ADHD or ADD	Yes	No	Who?
Learning or reading problems	Yes	No	Who?
Intellectual Disability	Yes	No	Who?
Seizures (epilepsy, convulsions)	Yes	No	Who?
Similar problems to child	Yes	No	Who?
Special Education/Resource in school	Yes	No	Who?
Speech/language delays/disorders	Yes	No	Who?
Motor delays/difficulty in walking	Yes	No	Who?
Visual problems	Yes	No	Who?

Do(es) any disease(s) run in the family? Yes_____ No_____ If yes, what?

Please list any unusual and/or traumatic family event in this child's life which you feel may have affected his/her development and ability to function (i.e., birth of a sibling, deaths in the family, divorce, illnesses, frequent school changes, moves, etc.)

Incident	Child's Age	Comments

Please give any other information that you think would be helpful to us in the evaluation/treatment of your child: