Patient History and Environmental Assessment

Please fill out this form to the best of your knowledge. If some questions are not applicable to you or your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

GENERAL INFORMATION:

Child's name: _____ _____ _____ Date: _____
Last Middle First

Form completed by: _____ Relationship to child: _____

(If child is adopted, please state child's age at adoption and date of adoption: _____ _____

International adoption? Y/N)

Gender of child: ___ Male ___ Female Birth date of child: _____ Age: _____

Language(s) other than English spoken in home: _____ Usual language of child: _____

Name of child's current school: _____

School district: _____

Address of school: _____

Telephone: _____ Grade: _____ Teacher: _____

CURRENT CONCERNS:

What is the main reason for your child's consultation?

_____

_____

How long has your child had these problems? How long have you been concerned about your child's difficulties?

_____

_____

Where does your child exhibit these problems? (Check all that apply)

____ Home ____ School _____ Other (specify) _____

What, if anything, makes the problem(s) worse? _____

_____

What, if anything, makes the problem(s) better? _____

_____

PAST MEDICAL HISTORY

Please check which of the following your child has had and note the age, any complications, and frequency below:

Yes	No		Yes	No	
☐	☐	Hospitalizations	☐	☐	Vision problems (date of last exam:____)
☐	☐	Surgery	☐	☐	Hearing problems (date of last exam:___)
☐	☐	Trauma (stitches/broken bones)	☐	☐	Asthma
☐	☐	Head trauma	☐	☐	Allergies (list:_____)
☐	☐	Loss of consciousness	☐	☐	Stomach aches
☐	☐	Coma	☐	☐	Excessive vomiting
☐	☐	Seizures	☐	☐	Pica (eating non-food items)
☐	☐	Tics (motor/vocal)	☐	☐	Diabetes
☐	☐	Staring spells	☐	☐	Malnutrition
☐	☐	Tremor	☐	☐	Gastrointestinal difficulties
☐	☐	Poor muscle tone	☐	☐	Chronic ear infections (PE tubes: Y/N)
☐	☐	Falls frequently	☐	☐	Other infections
☐	☐	Anemia	☐	☐	Elevated lead levels
☐	☐	Persistent high fever	☐	☐	Accidental poisoning
☐	☐	Headaches (migraines: Y/N)	☐	☐	Leukemia
☐	☐	Respiratory difficulties	☐	☐	Neoplasm (cancerous: Y/N)
☐	☐	Cardiovascular/heart disease	☐	☐	Sickle cell
☐	☐	Endocrine/thyroid problems	☐	☐	Other medical problems

Please explain all "Yes" answers from Past Medical History Checklist:

_____

_____

_____

SERVICES/INTERVENTION SOUGHT PREVIOUSLY:

- ☐ Medical Evaluation
- ☐ Brain Scan (CT, MRI)
- ☐ Occupational/Physical Therapy
- ☐ School Modifications
- ☐ Psychiatric Exam
- ☐ Laboratory Test (EEG, EKG)
- ☐ Educational Testing
- ☐ Tutoring
- ☐ Medication
- ☐ Genetic/Chromosome Test
- ☐ Special Education
- ☐ Psychological Counseling or Therapy
- ☐ Neurological Exam
- ☐ Speech/Language Therapy
- ☐ Neuropsychological Assessment
- ☐ Other

What else have you tried to do to help your child with these problems?

_____

_____

_____

MEDICAL HISTORY:

Medication	Dosage	Frequency	Start date – End date	Reason for discontinuing

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ALLERGIES:

Does your child have any allergies to drugs? If so, please indicate the reaction.

Medication	**Reaction**

FAMILY STATUS:

Marital Status of Parents:

☐ Married for ____ years ☐ Never married ☐ Separated ☐ Divorced ☐ Widowed

Child currently lives with: (Please check all that apply)

☐ Natural Mother ☐ Natural Father ☐ Stepmother ☐ Stepfather

☐ Adoptive Mother ☐ Adoptive Father ☐ Foster Mother ☐ Foster Father

☐ Grandmother ☐ Grandfather ☐ Other (Specify) _____

FAMILY STRESSORS OR EVENTS:

Have any of the following events occurred within the past 12 months?

☐ Parents divorced or separated ☐ Parent changed job ☐ New baby at home

☐ Child changed schools ☐ Family accident or illness ☐ Death in family

☐ Conflict in family ☐ Child repeated a grade ☐ Family financial problems

☐ Family moved ☐ Family changes ☐ Other: _____

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FAMILY HISTORY:

Has anyone in your family experienced the following: (Biological Relationship to the Child)

Medical Condition	Yes/No	Immediate Family			Father's Relatives	Mother's Relatives
		Dad	Mom	Sibling		
Learning Problems	☐ Yes ☐ No					
ADD/ADHD	☐ Yes ☐ No					
Mental Retardation	☐ Yes ☐ No					
Autism Spectrum	☐ Yes ☐ No					
Speech Delay	☐ Yes ☐ No					
Tourette's Syndrome – Tic Disorder	☐ Yes ☐ No					
Neurological Disorders	☐ Yes ☐ No					
Epilepsy/Seizure Disorder	☐ Yes ☐ No					
Bipolar Disorder (Manic Depression)	☐ Yes ☐ No					
Depression	☐ Yes ☐ No					
Panic Attacks	☐ Yes ☐ No					
Anxiety	☐ Yes ☐ No					
Obsessive Compulsive Disorder	☐ Yes ☐ No					
Schizophrenia	☐ Yes ☐ No					
Alcoholism/Substance Abuse	☐ Yes ☐ No					
Genetic Syndromes	☐ Yes ☐ No					
Endocrine/Hormonal Problems	☐ Yes ☐ No					
Other	☐ Yes ☐ No					

Have any blood relatives to your child experienced problems similar to those your child is currently experiencing? Y/N

If yes, please describe: _____

_____

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SLEEP HABITS:

Do you feel your child has sleep problems? ___ Yes ___ No (if yes, how long has he/she had these problems? _____)

Where does your child sleep?

- ☐ Own bedroom
- ☐ Shared bedroom (with whom: _____)
- ☐ Room other than a bedroom (describe: _____)

Does your child currently experience:

Snoring	☐ Yes	☐ No
Restlessness	☐ Yes	☐ No
Difficulty falling asleep	☐ Yes	☐ No (if yes, how long does it take? _____)
Waking in the night	☐ Yes	☐ No (if yes, how many times per night? ____How long to fall back asleep? ____)
Nightmares	☐ Yes	☐ No (if yes, how often? _____)
Night Terrors	☐ Yes	☐ No (if yes, how often? _____)
Sleep Walking/Talking	☐ Yes	☐ No (if yes, how often? _____)

Does your child nap? ___Yes ___No How many hours total does your child currently sleep at night? _____

EMOTION AND BEHAVIOR:

Please describe briefly any emotional or behavioral problems at *home*:

_____

_____

Please describe briefly any emotional or behavioral problems at *school*:

_____

_____

Has your child ever been suspended/expelled from school? ____Yes ____No

If yes, how many times? _____ Why? _____

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Please check any of the following behaviors your child has displayed frequently or intensively within the last 6 months:

☐ Fainting/falling	☐ Anxiety	☐ Low frustration tolerance	☐ Physical aggression
☐ Clumsiness	☐ Unusual fears	☐ Impulsivity	☐ Stealing
☐ Shy/timid	☐ Avoidance	☐ Hyperactivity	☐ Use of profanity
☐ Social isolation	☐ Laziness	☐ Attention seeking	☐ Skipping school
☐ Lack of confidence	☐ Obsessive-compulsive behaviors	☐ Irritability	☐ Fire setting
☐ Low self-esteem	☐ Stereotyped/repetitive behaviors	☐ Temper tantrums	☐ Destructiveness
☐ Crying episodes	☐ Memory loss	☐ Oppositional behavior	☐ Cruelty to animals
☐ Unhappiness	☐ Poor concentration	☐ Noncompliance	☐ Gang involvement
☐ Concern with weight	☐ Short attention span	☐ Defiance	☐ Cigarette use
☐ Sleep problem	☐ Distractibility	☐ Lying	☐ Alcohol/substance use
☐ Other:			

Please provide additional information about any of the above you feel would be helpful: _____

_____

_____

_____

EATING HABITS:

How would you rate your child's appetite? ____Poor ____Fair ____Good ____Excellent

Is your child a picky eater? ____Yes ____No (If yes, please describe: _____)

EDUCATIONAL HISTORY:

Has your child received DDI (Developmental Delay Intervention) services? ____Yes ____No

If yes, from when to when? _____

Has your child received PPCD (Preschool Program for Children with Disabilities) services? ____Yes ____No

If yes, from when to when? _____

Were there any adjustment problems in preschool? ____Yes ____No

If yes, please explain: _____

Were you concerned about your child's ability to succeed in preschool? _____Yes ____No

If yes, please explain: _____

Present class placement:
- ☐ Regular class
- ☐ Special class (specify: _____)
- ☐ Bilingual
- ☐ English as a Second Language (ESL)

Has testing been completed by school? ____Yes ____No Date: _____

If so, please attach a copy of the school evaluation

Has your child ever been retained? ____ Yes ____No (if yes, what grade? _____ Why? _____)

Briefly describe your child's current academic difficulties:

_____

_____

At what level do you feel your child is functioning compared to other children the same age? _____

ACADEMIC PERFORMANCE:

Please list your child's current grades (if applicable):

Math: _____ Science: _____

Reading: _____ Social Studies: _____

Spelling: _____ Language Arts: _____

Have any instructional modifications been attempted?

___Oral tests ___Peer teaching ___Additional instructions

___Repeated review ___Behavior check cards/charts ___Reduced paper and pencil work

___Preferential seating ___Control of distractions ___Predictable routines and classroom rules

___Study carrel ___Study sheets ___Extended time to complete assignments

___Outlines ___Increased positive feedback ___Shortened or modified assignments

___Positive reinforcers ___Behavior modification program

Are these modifications part of a formal education plan (such as an IEP/504)? ____Yes ____No