

Office use:

Last Name: _____

Evaluation Date: _____

Evaluation Time: _____

**CONFIDENTIAL PERSONAL HISTORY
FOR CHILDREN AND YOUNG ADULTS**

Today's Date: _____

Family Name: _____ Child's Name: _____

Address: _____ Birthdate: _____

_____ Age: _____ Grade: _____

_____ School: _____

Home phone number: _____ Completed by: _____

Mother's Address: _____ Father's Address: _____

Home phone number: _____ Home phone number: _____

Referred by: _____

Address _____

Phone _____

May we send a thank you letter to your referral source? ____yes ____no

The Creative Listening Center has my permission to send a thank you letter to my referral source indicating that my child has been seen for an evaluation. No other information will be released without written consent.

Parent or Gaurdian: _____ Date: _____

FAMILY MEMBERS

	Age	Sex	Adopted		Education/Occupation	Handedness	
Father _____	_____	_____	Yes	No	_____	R	L
Mother _____	_____	_____	Yes	No	_____	R	L
Children _____	_____	_____	Yes	No	_____	R	L
_____	_____	_____	Yes	No	_____	R	L
_____	_____	_____	Yes	No	_____	R	L
_____	_____	_____	Yes	No	_____	R	L

Marital Status of Parents: Married: _____ Separated: _____ Divorced: _____ Other: _____

What are your concerns for your child?

Academic: _____

Personal: _____

Social: _____

FAMILY ADAPTATION

At home, how would you describe his/her general adjustment?

Poor _____ Fair _____ Good _____ Excellent _____

How does he/she get along with each member of the family?

Father _____

Mother _____

Siblings _____

Have there been any traumatic family events in the course of this child's development?

Have there been any major moves? (City to city, country to country)

Pregnancy (If child is adopted, turn to page 5)

What kind of experience was the pregnancy for both mother and father?

Father _____

Mother _____

More specifically:

	<u>Yes</u>	<u>No</u>	<u>Comments</u>
Was it planned?	_____	_____	_____
Were there complications?	_____	_____	_____
shock	_____	_____	_____
loss of a loved one	_____	_____	_____
accident	_____	_____	_____
health problems	_____	_____	_____
confinement to bed	_____	_____	_____
tiredness, fatigue	_____	_____	_____
other	_____	_____	_____
Was mother exposed to noise?	_____	_____	_____
Did mother smoke?	_____	_____	_____
Did mother consume alcohol?	_____	_____	_____
Did mother take any medication?	_____	_____	_____
Did mother talk much?	_____	_____	_____
Was mother physically active?	_____	_____	_____
Did mother sing?	_____	_____	_____
Did mother play a musical instrument?	_____	_____	_____
Were any previous pregnancies complicated?	_____	_____	_____

Which language was spoken by mother? _____

LABOR AND DELIVERY

Describe your experience during labor and delivery_____

More specifically:

	<u>Yes</u>	<u>No</u>	<u>Comments</u>
Full term?	_____	_____	_____
Length of labor?	_____	_____	_____ hrs
Forceps used?	_____	_____	_____
High forceps required?	_____	_____	_____
Delivery position? (e.g. breech)	_____	_____	_____
Caesarean birth? (reason)	_____	_____	_____
Birth weight?	_____	_____	_____
APGAR rating?	_____	_____	_____
Cried immediately?	_____	_____	_____
Required special treatment? (i.e. required oxygen, had jaundice, etc.)	_____	_____	_____
Did the newborn have immediate physical contact with the mother?	_____	_____	_____
Was there a positive bonding experience between mother and newborn at birth?	_____	_____	_____
Was the newborn breastfed immediately?	_____	_____	_____
Describe any separations from mother during first days of life	_____	_____	_____
Did mother experience any post-partum depression?	_____	_____	_____

ADOPTION

Describe the circumstances surrounding the adoption.

More specifically:

Age when adopted? _____

Prior foster homes? _____

Physical appearance: _____

Response to new home: _____

Is your child aware of adoption? _____

INFANCY

Going back to the first two years of the child's life, what type of baby was he/she?
(feeding, sleeping, activity level)

More specifically:

	<u>Yes</u>	<u>No</u>	<u>Comments</u>
Breastfed?	_____	_____	_____
Extended separations during first two years? (over 3 days)	_____	_____	_____
Specific health problems during this period?	_____	_____	_____
Toilet trained? (age)	_____	_____	_____
Thumb sucking? (until what age)	_____	_____	_____
Feeding or sleeping problems?	_____	_____	_____

CHILDHOOD ILLNESSES

Has your child had any of the following childhood illnesses?

	Age	How Often
___ respiratory problems	___	_____
___ high fever	___	_____
___ meningitis	___	_____
___ ear infections	___	_____
___ adenoid problems	___	_____
___ frequent colds	___	_____
___ strep throat	___	_____
___ allergies	If yes, please list: _____	

Has he/she ever been hospitalized? Yes _____ No _____

If yes, please list reasons:

Has he/she ever had a serious accident/injury? Yes _____ No _____

If yes, please list accidents:

Check the items below which have been a problem and give details.

Asthma	___	_____
Bronchitis	___	_____
Skin problems	___	_____
Gastro-Intestinal problems	___	_____
Convulsions	___	_____
Epilepsy	___	_____
Nightmares	___	_____
Fitful sleep	___	_____
Bedwetting	___	_____
Nail Biting	___	_____

Are there any other medical illnesses or conditions which have been diagnosed?

Is your child in good general health at the present time? _____

Is your child currently taking any prescribed medication? _____

If yes, please describe (name and dose) _____

When was your child's most recent medical check-up?

Date _____ Doctor's Name _____

SENSORI-MOTOR DEVELOPMENT

How would you describe your child's motor development?

Normal _____ delayed _____ advanced _____

At what age did your child: crawl _____ walk _____

develop hand preference: Right _____ Mixed _____ Left _____

Is your child unusually sensitive to touch or are some clothes "scratchy"? _____

If yes, please describe: _____

General co-ordination? poor _____ fair _____ good _____ excellent _____

General balance: poor _____ fair _____ good _____ excellent _____

Does your child participate in sports? (type) _____

VISUAL DEVELOPMENT

Has your child experienced any problems with his/her eyesight or vision? _____

Are there any current problems of which you are aware? _____

When was the last time his/her eyesight was tested? _____

AUDITORY DEVELOPMENT

Has your child experienced any problems with his/her hearing? (operations, infections, tubes) _____

Ear infections? seldom _____ sometimes _____ often _____

 Mild _____ moderate _____ severe _____

Are there any current hearing problems of which you are aware? _____

SPEECH AND LANGUAGE DEVELOPMENT

How would you describe your child's speech and language development?

 normal _____ delayed _____ advanced _____

Did your child begin speaking in single words, then two, then a sentence? **or**

Did your child not talk for a long while, then all of a sudden speak in complete sentences?

First words (age) _____

Describe any speech related problems: _____

Has your child had any previous **ASSESSMENTS**?

	<u>Yes</u>	<u>No</u>	<u>Place</u>	<u>Date</u>
Medical	_____	_____	_____	_____
Audiological	_____	_____	_____	_____
Speech	_____	_____	_____	_____
Educational	_____	_____	_____	_____
Psychological	_____	_____	_____	_____

Comments: _____

Has your child been previously diagnosed as having a specific disorder?

Has your child received any special education or special therapy?

Have there been any specific events or traumas linked with the onset of your child's difficulties? _____

Is your marital situation stable and positive at this time?

What, if any, stresses are affecting your family at this time?

Which language (s) is spoken at home? _____

Are there other individuals or family members living at home? _____

EDUCATION

In general, how would you describe your child's experience/learning at school from kindergarten to the present time?

How did your child adapt to the first day (s) at school or pre-school

Mostly positive _____ Mixed _____ Mostly negative _____

How old was he/she? _____

How much time did he/she attend? _____ per week

Please give us more detailed information about any difficulties your child encountered in school beginning with the earliest experience

Initial school adjustment_____

Pre-school/Daycare_____

Primary (K-Gr. 3)_____

Junior (Gr. 4-6)_____

Intermediate (Gr. 7-8)_____

High School (Gr. 9-12)_____

Has there been remedial help given outside the school system?

Yes_____ No_____

If yes, describe:_____

Can he/she listen to more than one conversation at once?_____

Does he/she recall how things look?_____

Does he/she like movies and museums?_____

Does he/she like dancing and sports?_____

Does he/she take risks or learn only when very comfortable?_____

BEHAVIOR/CHARACTER

How would you describe your child?_____

What are your child's strengths?_____

What are your child's weaknesses?_____

Have there been any specific behavior problems in the course of your child's development?

What kind of interests and activities does your child have? (hobbies, sports, clubs) Please list them in order of preference beginning with the favorite activity.

How would you describe your child's social adjustment?

With peers?_____

With adults?_____

Please add any other comments you might have regarding your child's behavior and character:

GOALS

What are your goals for your child's program? Please be as specific as possible.

1. _____

2. _____

3. _____

4. _____

ADDENDUM:

If you are temporarily the child's primary caregiver, please add:

(1) The relationship you have with the child

(2) Any additional comments you feel would be helpful

