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Health History Questionnaire

Name_____ DOB:_____ Today's Date: _____

Handedness (circle): Right / Left / Ambidextrous Form completed by?_____

Issues you would like to address:_____

_____

Areas of strength:

_____

Areas of weakness:

_____

Any of the following currently?	Never/Rarely	Often	Frequently
Behavioral Problems	[ ]	[ ]	[ ]
School Study Problems	[ ]	[ ]	[ ]
Sleep changes	[ ]	[ ]	[ ]
Irritable mood	[ ]	[ ]	[ ]
Anger outbursts	[ ]	[ ]	[ ]
Social isolation or difficulty	[ ]	[ ]	[ ]
Frequent worry/panic	[ ]	[ ]	[ ]
Feeling sad/crying spells	[ ]	[ ]	[ ]
Obsessive and/or compulsive behaviors	[ ]	[ ]	[ ]
Paranoid thoughts	[ ]	[ ]	[ ]
Aggressive behavior	[ ]	[ ]	[ ]
Seeing objects or hearing voices that are not real	[ ]	[ ]	[ ]

Developmental History:

Complications with pregnancy, labor or birth or hospitalizations following birth:

_____

Any seizures, convulsions unrelated to fever? Yes /No If yes, at what age_____
Any serious illness or hospitalization as a child? Yes/No If yes, what? _____
Has child had a history of frequent ear infections? Yes/No If yes, at what age(s): _____

Ever any head injuries? Yes /No If yes, at what age(s)? _____
If yes, what happened? _____
Was child unconscious? Yes/ No For how long:_____

Current hearing or vision problems? Yes/No (please specify) _____

Current Medications: _____

Sleep	Never/Rarely	Often	Frequently
Regular Sleep Schedule	[ ]	[ ]	[ ]
Wake during the night	[ ]	[ ]	[ ]
Snore	[ ]	[ ]	[ ]
Restless	[ ]	[ ]	[ ]
Sleep walking	[ ]	[ ]	[ ]
Talks in sleep	[ ]	[ ]	[ ]
Wake without help in am	[ ]	[ ]	[ ]
Feel sleepy during the day	[ ]	[ ]	[ ]

Bed time _____ Wake time_____ How long to fall asleep on average? _____

Psychological History

Any diagnoses (please specify diagnosed by whom and when diagnosed:_____
_____

Any medication prescribed? (type/dosage/prescribing physician)_____
Is medication helpful? If so, how is it helpful?_____

Any psychotherapy or counseling? If so, with whom and when? _____
Is or was it helpful?_____

Psychiatric hospitalizations (reason, date, location)
_____

Any trauma or significant life events? (please describe)_____

Any past or current difficulties:	Never	Sometimes	Often	Always
Trouble sustaining attention	[ ]	[ ]	[ ]	[ ]
Lacks attention to detail	[ ]	[ ]	[ ]	[ ]
Disorganized	[ ]	[ ]	[ ]	[ ]
Time management	[ ]	[ ]	[ ]	[ ]
Impulsive	[ ]	[ ]	[ ]	[ ]
Poor memory	[ ]	[ ]	[ ]	[ ]
Oppositional/argumentative	[ ]	[ ]	[ ]	[ ]
Makes careless mistakes	[ ]	[ ]	[ ]	[ ]
Doesn't like to read or write	[ ]	[ ]	[ ]	[ ]
Difficulty initiating tasks independently	[ ]	[ ]	[ ]	[ ]
Slow personal tempo	[ ]	[ ]	[ ]	[ ]

Family History:

Mother's education level?_____ Occupation? _____
Father's education level? _____ Occupation? _____
Siblings (name and age): _____
Any immediate or extended family history of difficulty with reading, language, attention, academics, emotional struggles, seizures, psychological diagnoses? Please describe: _____
_____
_____

Compared to other children		
Were any of these delayed or advanced? Walking Talking Fine motor Gross motor Toilet training Separating Eye contact _____ **Are these automatic?** Telling time : Yes/No Left- Right : Yes/ No Months of the year: Yes/No	**Have these occurred?** Banging head Rocks back and forth Repetitive behaviors/fixations Difficulty sitting in a chair Uncomfortable with physical affection Limited facial expressions Poor spelling Trouble filtering background noises _____ **Friendships:** Few or no friends: Yes/No Invited to parties: Yes/No Accepted by peers: Yes/No	**Early Intervention Services:** (When?) Speech and Language _____ Occupational Therapy (OT) _____ Reading Support _____ Summer School _____ MCAS prep class _____ **Any Sensory Sensitivities?** (Give Examples) Texture _____ Sound _____ Light _____ Touch _____
Are any of these currently true? (Please describe on back of this page) Difficulty learning to read. Difficulty or avoids texting Reverses letters (such as b/d, p/q) Messy handwriting Trouble getting to the point in conversations. Takes a long time to complete tasks Trouble getting thoughts from my brain to the paper		**Academic Strengths:** _____ _____ Favorite Subject: _____ **Academic Weaknesses:** _____ _____ Least Favorite Subject: _____

Educational History (Please use back of paper if additional space is needed)

Current grade? _____ Ever repeated a grade? Yes/No If yes, which one? _____

	Name of School Public or Private?	**Any Concerns?**
Elementary		
Middle		
High School		

Is there an Individualized Education Plan (IEP) or 504 plan? Yes/No
Is there current resource room help now? Yes/ No If yes, how often? _____
For which academic skills?_____ _____
Has your child ever completed a core evaluation or neuropsychological assessment? Yes/No When:_____

Any tutoring? If so when, how often and for what?): _____