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:

____

Current challenges:

____

Any of the following currently?	Never/Rarely	Often	Frequently
Reduced motivation	[ ]	[ ]	[ ]
Academic or employment struggles	[ ]	[ ]	[ ]
Sleep changes	[ ]	[ ]	[ ]
Irritable mood	[ ]	[ ]	[ ]
Anger outbursts	[ ]	[ ]	[ ]
Social isolation	[ ]	[ ]	[ ]
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	[ ]	[ ]	[ ]
Wakes during the night	[ ]	[ ]	[ ]
Snores	[ ]	[ ]	[ ]
Sleep talking or walking	[ ]	[ ]	[ ]
Wake without help in am	[ ]	[ ]	[ ]
Feels or looks 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?____

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)____

Describe life at home on a typical day: ____

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 peers:

Were any of these delayed or advanced? (circle)

Walking
Talking
Fine motor
Gross motor
Separating
Eye contact

Are these automatic?

Telling time : Yes/No
Left- Right : Yes/ No
Months of the year: Yes/No
Basic math facts: Yes/No

Social:

Few or no friends: Yes/No
Invited to parties: Yes/No

Have these occurred?

Banging head
Trouble filtering background noises
Repetitive behaviors/fixations
Difficulty sitting in a chair
Uncomfortable with physical affection

Early Intervention Services: (When?) ______________________________

Speech and Language? ____________
Occupational Therapy? ____________
Reading Support? ________________

Any Sensory Sensitivities? (Circle)
Texture/sound/light/touch/other
Examples: ______________________

Effort and Motivation
Rate your child's effort: (poor, average, strong)

Reading:__________________________
Writing: __________________________
Math:____________________________
Science: _________________________
Foreign language: __________________
Homework:________________________

Communicates well? Yes/No
Is confident? Yes/No
Is independent? Yes/No

Are any of these currently true? (Please describe on back of this page)

Difficulty learning to read
Reverses letters (such as b/d, p/q)
Messy handwriting
Trouble getting to the point in conversations
Takes a long time to complete tasks compared to peers
Trouble getting thoughts from my brain to the paper

Extra Curricular Activities:

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		
College		

Is there an Individualized Education Plan (IEP) or 504 plan? Yes/No
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?): ______________________________________