Growing Healthy Children
Therapy Services, Inc.
www.GHCOT.com

STUDENT INFORMATION AND PERSONAL HISTORY

Today's Date:_____ Completed by:_____

Last Name:_____ Child's Name:_____

Address: _____ Birthdate:_____Age:_____

City, State, Zip: _____ Gender: _____

_____ Ethnicity:_____

CONTACT INFORMATION

Mother's Name: _____ Father's Name: _____

Address:_____ Address:_____

_____ _____

Phone (H): _____ Phone (H):_____

Phone (C): _____ Phone (C):_____

Emergency Contact:_____
name relationship phone

School:_____ Grade in school: _____

Teacher's Name:_____ Type of classroom:_____

Child's Health Care Providers (including Primary Care Physician):

Name:_____Profession:_____Phone:_____
Address:_____

Name:_____Profession:_____Phone:_____
Address:_____

Name:_____Profession:_____Phone:_____
Address:_____

Date of Child's last medical checkup:_____Height_____Weight_____

Are there any medical precautions the therapist should be aware of when working with your child?

_____

_____

_____

_____

FAMILY MEMBERS

		Age	Sex	Adopted	Occupation	Handedness
Father:	_____	___	___	yes no	_____	R L
Stepfather	_____	___	___	yes no	_____	R L
Mother	_____	___	___	yes no	_____	R L
Stepmother	_____	___	___	yes no	_____	R L
Siblings	_____	___	___	yes no	_____	R L
	_____	___	___	yes no	_____	R L
	_____	___	___	yes no	_____	R L

Marital Status of Parents: ____Married ____Separated ____Divorced ____Other

Mother's Education: ___Less than High School
___High School or GED
___College
___Post College (grad school)

Stepmother's Education___Less than High School
____High School or GED
____College
____Post College (grad school

Father's Education: ___Less than High School
___High School or GED
___College
___Post College (grad school)

Stepfather's Education___Less than High School
____High School or GED
____College
____Post College (grad school

PERSONALITY PROFILE

What are your child's gifts/strengths? _____
_____
_____
_____
_____
_____
_____
_____

What do you enjoy most about your child and family?_____
_____
_____
_____
_____
_____
_____

What are the presenting problems for your child? (All categories below may not apply)
Academic:_____
_____

Activities of daily life (eg. eating, dressing):_____
_____

Relationships:_____

_____

Sensory:_____

_____

Motor:_____

_____

Play:_____

_____

Other:_____

_____

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.

_____

_____

_____

Has your child been diagnosed with (PLEASE CHECK ALL THAT APPLY):

___ADD
___ADHD
___Anxiety Disorder or Mood Disorder (specify):_____
___Autistic Spectrum Disorder
___Cognitive Delay
___Down Syndrome
___Dyslexia
___Emotional disorder (specify):_____
___Fragile X Syndrome
___Learning Disabilities (specify if possible):_____
___Sensory Processing Disorder or Sensory Integration Dysfunction
___Tourette's Syndrome
___Other (specify):_____

Please note, who provided the diagnosis and based on what criteria (i.e., test scores, comprehensive clinical evaluation, genetic study, etc.):_____

_____

_____

_____

_____

_____

_____

MEDICATIONS

List any medications your child has received **in the past**:

Medication:_____ Purpose:_____ When taken:_____

Medication:_____ Purpose:_____ When taken:_____

Medication:_____ Purpose:_____ When taken:_____

Medication:_____ Purpose:_____ When taken:_____

Medication:_____ Purpose:_____ When taken:_____

List any medications your child is **currently** taking:

Medication:_____ Purpose:_____ When taken:_____

Medication:_____ Purpose:_____ When taken:_____

Medication:_____ Purpose:_____ When taken:_____

Medication:_____ Purpose:_____ When taken:_____

Medication:_____ Purpose:_____ When taken:_____

FAMILY ADAPTATION

How would you describe your child's general adjustment at home? __Poor __Fair __Good __Excellent

How does your child get along with each member of the family?

Father_____

Stepfather_____

Mother_____

Stepmother_____

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, skip to Adoption Section)

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

Father:_____

Mother:_____

	Yes	No	Comments
Was it planned?	___	___	_____
Were there complications?	___	___	_____
shock	___	___	_____
severe stress	___	___	_____
loss of a loved one	___	___	_____
accident	___	___	_____
health problems, specify	___	___	_____
confinement to bed	___	___	_____
other	___	___	_____
Was mother exposed to loud noises?	___	___	_____
Did mother smoke?	___	___	_____
Did mother consume alcohol?	___	___	_____
Did mother take any medication? specify	___	___	_____
Did mother talk much?	___	___	_____
Was mother physically active?	___	___	_____
Were any previous pregnancies complicated?	___	___	_____

LABOR AND DELIVERY

Describe your experience during labor and delivery:_____

_____

_____

		Comments
Length of labor?	____hours	_____
Premature: specify	Yes__ No__	_____
Forceps used	Yes__No__	_____
High forceps required	Yes__No__	_____
Suction	Yes__No__	_____
Delivery position (ex: breech)	_____	
Caesarean birth (reason)	Yes__No__	_____
Birth weight	___lbs___oz	_____
APGAR ratings (if known)	___ ___	_____
Cried immediately	Yes__No__	_____

Required special treatment (i.e. required oxygen, had jaundice, etc.) Yes__No__ _____

Birth injuries: specify Yes__No__ _____

Did the newborn have immediate physical contact with the mother? Yes__No__ _____

Was there a positive bonding experience between mother and newborn at birth? Yes__No__ _____

Describe any separations from mother during first days of life:_____

Did mother experience any post-partum depression? Yes__No__ _____

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 his/her adoption?_____

INFANCY & TODDLERHOOD

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

_____
_____
_____
_____
_____
_____
_____

	Yes	No	Comments
Breastfed	___	___	_____
Extended separations during first two years (over 3 days)	___	___	_____
Specific health problems during this period	___	___	_____
Thumb sucking/pacifier (until what age)	___	___	_____
Feeding problems	___	___	_____
Sleeping problems	___	___	_____
Colic or "fussy baby"	___	___	_____
Prefer certain positions as an infant (describe)	___	___	_____
Dislike lying on stomach	___	___	_____
Dislike lying on back	___	___	_____
Able to self soothe	___	___	_____
On a regular schedule	___	___	_____
Enjoy bouncing	___	___	_____
Become calmed by car rides or infant swings	___	___	_____
Become nauseated by car rides or infant swings	___	___	_____
Crawled (at what age)	___	___	_____
Toe walker (until what age)	___	___	_____
Go through "terrible twos"	___	___	_____

Describe your child's toddler stage:_____

_____

CHILDHOOD ILLNESSES/PROBLEMS

	Age	Comments/Deficits
___ear infections	___	None / A couple / Many _____
___tubes in ears	___	_____
___respiratory problems	___	_____
___high fever	___	_____
___meningitis	___	_____
___adenoid problems	___	_____
	Age	Comments/Deficits
___frequent colds	___	_____
___strep throat	___	_____

___Allergies If yes, please specify:_____
_____

Check the items below which have been a problem and provide details:

___Asthma _____
___Bronchitis _____
___Skin problems _____
___Gastro-Intestinal problems _____
___Seizures _____
___Epilepsy _____
___Nightmares _____
___Sleep _____
___Bedwetting _____
___Nail Biting _____
___Broken limbs _____
___Other _____

Has he/she ever been hospitalized? Yes____ No____
If yes, list reasons:_____
_____

Has he/she ever had a serious accident/injury? Yes____ No____
If yes, list accidents:_____
_____

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

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

DEVELOPMENTAL MILESTONES

(Give approximate ages if remembered, or comment on anything unusual)

Rolling over_____ Walk_____ Say words_____

Sit alone_____ Chew solid food_____ Say sentences_____

Crawl_____Drink from cup_____

Was crawling phase brief? Yes____ No____ Absent? Yes___ No___

Did child use a walker (rolling plastic seat)? Yes____ No___ If yes, how often?_____

Experience hesitancy or delays in learning to go down stairs? Yes_____ No_____

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? Yes No

Did your child not talk for a long while, then all of a sudden speak in complete sentences? Yes No

Do you or others have difficulty understanding what your child says? Yes No

First words and at what age:_____

Describe any speech related problems:_____

_____

_____

SENSORY AND MOTOR DEVELOPMENT

Please check any that apply:

_____ My child seems to be overly sensitive to sensory experiences more so than most people:
___auditory ___tactile ___visual ___movement ___taste ___smell

_____ My child doesn't seem to react to sensory experiences as readily as most people:
___auditory ___tactile ___visual ___movement ___taste ___smell

_____ My child actively seeks out sensory experiences more so than most people:
___auditory ___tactile ___visual ___movement ___taste ___smell

_____ My child has difficulty differentiating sensory experiences
(ex. confuses sounds, can't find objects in drawer or bag without looking, bumps into things)

Describe:_____

_____

_____

_____ My child has trouble learning new movements.

_____ My child tends to be clumsy and has balance and coordination problems.

PREVIOUS TESTING AND TREATMENTS

Has your child had any previous ASSESSMENTS or TREATMENTS
Please attach relevant reports.

	ASSESSMENTS			TREATMENTS		
	Yes	No	Place/Date	Yes	No	Place/Date
Medical	___	___	_____	___	___	_____
Audiological	___	___	_____	___	___	_____
Speech	___	___	_____	___	___	_____
Educational	___	___	_____	___	___	_____
Psychological	___	___	_____	___	___	_____
Occ. Therapy	___	___	_____	___	___	_____
Other	___	___	_____	___	___	_____

Comments:_____

_____

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? (other than immediate family)

_____

_____

EDUCATION

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?_____

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

_____

_____

_____

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 **inside** the school system? Yes_____ No_____

If yes, describe:_____

_____

GOALS

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

1._____

_____

_____

2._____

_____

_____

3._____

_____

_____

4._____

_____

_____

5._____

_____

_____

How did you hear about Growing Healthy Children? _____