I LEARN
INNOVATIVE LEARNING PROFESSIONALS, LC

CONFIDENTIAL PERSONAL HISTORY FOR CHILDREN AND YOUNG ADULTS

(You may attach additional sheets or use backs as needed.)

Child's Full Name: _____

Address:_____

_____

State: _____ ZIP: _____

Home phone number: _____

Other phone(s): _____

Today's Date:_____

Birthdate: _____ Age:_____

Grade: _____

School:_____

Family E-mail: _____

Completed by: _____

Referred by:_____

FAMILY MEMBERS

*Please complete, circle when appropriate. Add **siblings**, **stepparents**, and **stepsiblings** as appropriate.*

Name	Age	Sex	Adopted	Lives With	Education	Occupation	Handedness
(mother)		M F	Yes No	Yes No			Right Left
(father)		M F	Yes No	Yes No			Right Left
(client & siblings)		M F	Yes No	Yes No			Right Left
		M F	Yes No	Yes No			Right Left
		M F	Yes No	Yes No			Right Left
		M F	Yes No	Yes No			Right Left
		M F	Yes No	Yes No			Right Left
		M F	Yes No	Yes No			Right Left

Marital Status of Parents: ❑ Married ❑ Separated ❑ Divorced ❑ Never Married ❑ Other: _____

MAIN CONCERNS What are your current 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 the family as a whole, as well as each member of the family?

PREGNANCY (If adopted, complete what you know, skip the rest.)

Pregnancy specifics:			
Was it planned?	Yes No	Did the mother smoke?	Yes No
Were there pregnancy complications?	Yes No	Did the mother consume illegal drugs? If yes, which ones?	Yes No
Were there health problems?	Yes No		
Did accidents/injuries occur in pregnancy?	Yes No	Did the mother consume alcohol?	Yes No
Was the mother confined to bed?	Yes No	Did the mother take any medication?	Yes No

Please explain:

LABOR AND DELIVERY

Was the pregnancy full term?	Yes No	What was the birth weight?	
How many weeks (or months)?		What were the APGAR ratings? (if known)	
What was the length of labor, in hours?		Was the birth Cesarean or Vaginal?	C V
Was pitocin used?	Yes No	Were there delivery complications?	Yes No
For how long, in hours?		Did the child cry immediately?	Yes No
Were forceps used?	Yes No	Did he/she require special treatment?	Yes No
Was the mighty-vac used?	Yes No		Yes No

Please describe the labor and delivery and explain any complications or problems (even minor ones).
Please describe the health of your child when he/she was born.

ADOPTION (if applicable)

Age when adopted: _____ # of prior foster homes: _____ Is your child aware of the adoption? ❑ Yes ❑ No
Please describe the circumstances surrounding the adoption, response to new home, and any other considerations or comments:

INFANCY

Considering the first two years of the person's life:			
Was he/she healthy?	Yes No	Were there extended separations?	Yes No
Were there eating or sleeping problems?	Yes No	Was s/he firmly attached emotionally?	Yes No

Please describe any problems noticed in infancy and describe what type of baby he/she was.

DEVELOPMENTAL HISTORY

Overall, with respect to reaching developmental milestones (e.g., walking, talking, toilet training, etc.) how would you describe your child's progress? (please check) ❑delayed ❑normal ❑advanced

Sensory-Motor Development

How would you describe your child's motor development (e.g., meeting developmental milestones such as rolling over, sitting up, crawling, walking)? (please check) ❑delayed ❑normal ❑advanced

At what age did your child: crawl_____ walk_____ develop hand preference_____
become daytime toilet trained_____

Is your child unusually sensitive to sensory experiences such as touch (e.g., overly sensitive to certain touches, "scratchy" clothes or tags, etc.), sounds (e.g., hide from sounds, act as though they hurt), sights, tastes, or smells? ❑Yes ❑No
If yes, please describe:

Currently, how is his/her general coordination: ❑ poor ❑ fair ❑ good ❑ excellent
how is his/her general balance: ❑ poor ❑ fair ❑ good ❑ excellent
how is his/her fine motor skills: ❑ poor ❑ fair ❑ good ❑ excellent

Does your child participate in sports? ❑Yes ❑No Please specify type and quality:

Please describe/explain any other problems (past or present) with sensorimotor development:

Speech and Language Development

How was your child's speech and language development? ❑ delayed ❑ normal ❑ advanced

What were your child's first words? At what age?_____

Has your child experienced problems with his/her speech and language? ❑ Yes ❑ No
If yes, please explain:

Childhood Losses, Trauma, or Stressors

Have there been any major moves? (city to city, country to country) ❑ Yes ❑ No

Have there been traumatic events in the course of this individual's development (major losses, significant accidents or physical trauma, child abuse, assaults, etc.)? ❑ Yes ❑ No

Have there been other stressors that could affect development (e.g., mother post-partum depression, early separations, etc.)? ❑ Yes ❑ No
If yes to any, please explain:

MEDICAL HISTORY

Child's primary doctor? _____

Current prescription medications & dosages?_____

Please indicate past medical problems and age. **(You may circle only yes responses for faster completion).**

Problem:	Yes No	Age:	Problem:	Yes No	Age:
Hospitalizations	Yes No		Anemia	Yes No	
Head injury	Yes No		Strep throat	Yes No	
Serious accident/injury	Yes No		Asthma/other respiratory problems	Yes No	
High fever (how high:_____)	Yes No		Allergies	Yes No	
Seizures/Epilepsy/Etc.	Yes No		Skin problems	Yes No	
Meningitis/other brain infection	Yes No		Nail biting	Yes No	
Stroke/Transient ischemic attack	Yes No		Chronic pain	Yes No	
Surgeries	Yes No		Headaches (migraines/tension/cluster)	Yes No	
Broken bones	Yes No		Bedwetting	Yes No	
Gastro-intestinal problems	Yes No		Sleep problems/Fitful sleep/Apnea	Yes No	
Ear infections	Yes No		Nightmares	Yes No	
Ear tubes placed	Yes No		Substance abuse (list kind below)	Yes No	
Diabetes(or hypoglycemia/glucose intolerance)	Yes No		Emotional/psychological problems	Yes No	
Thyroid problems	Yes No		Other:	Yes No	

Please describe any medical problems noted above or any others which have been suspected or diagnosed. Please give details of significant injuries, accidents, diseases, or conditions.
Please comment on your child's current health.

Sleep

At what time does your child typically go to bed? _____ Get up? _____
Does your child sleep through the night? ❑ Yes ❑ No Does your child wake rested? ❑ Yes ❑ No
Does your child snore? ❑ Yes ❑ No Does your child ever stop breathing while sleeping? ❑ Yes ❑ No
How much caffeine does your child drink in a typical day? _____
Comments:

Vision

Are there any problems with eyesight or vision? ❑ Yes ❑ No

Does your child need corrective lenses? ❑ Yes ❑ No

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

Assuming good/corrected vision, does your child have difficulty understanding/using what is seen? ❑Yes ❑No

Does your child complain of perceptual difficulties when reading (e.g., the words get blurry, letters blend or move, double images form)? ❑ Yes ❑ No

Please explain any 'Yes' answers above and describe any problems (past or present) with vision (or visual processing) including vision loss, operations, previous treatments, etc.:

Hearing

Has your child experienced any problems with his/her hearing? ❑ Yes ❑ No

Are there any current hearing problems of which you are aware? ❑ Yes ❑ No

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

Assuming good or corrected hearing, does your child seem to have any difficulty understanding, responding to, or using what he/she hears? ❑ Yes ❑ No

As a child were ear infections: ❑ seldom ❑ sometimes ❑ often? Were they: ❑ mild ❑ moderate ❑ severe

Please describe/explain any problems (past or present) with hearing (or auditory processing) including hearing loss, tube placement, operations, etc.:

MENTAL HEALTH HISTORY

Please indicate past mental health problems and age. (You may circle only yes responses for faster completion).

Problem:	Yes No	Age:	Problem:	Yes No	Age:
Learning disabilities/dyslexia	Yes No		Behavior/conduct/defiance problems	Yes No	
Intellectual limitations	Yes No		Alcoholism	Yes No	
ADHD/ADD	Yes No		Substance abuse (list)	Yes No	
Autism/Aspergers/DevelopmentalDisorder	Yes No		Sexual acting out	Yes No	
Depression	Yes No		Attachment problems	Yes No	
Bipolar Disorder (manic depression)	Yes No		Eating disorders	Yes No	
Suicidal Ideation	Yes No		Outpatient counseling	Yes No	
Self-harm (e.g., cutting, burning)	Yes No		Partial Hospitalization	Yes No	
Anxiety	Yes No		Inpatient Hospitalization	Yes No	
Schizophrenia/Psychosis	Yes No		Residential Placement	Yes No	

Please describe any mental problems noted above or any others which have been suspected or diagnosed.
Please comment on your child's current mental health status.

FAMILY MEDICAL HISTORY

Please indicate medical problems that are present in either mother's or father's immediate or extended family.

Psychological Condition:	Mother's side	Father's side	**Medical Condition:**	Mother's side	Father's side
Learning disabilities/dyslexia	Yes No	Yes No	Thyroid problems	Yes No	Yes No
Intellectual limitations	Yes No	Yes No	Diabetes/glucose intolerance	Yes No	Yes No
ADHD/ADD	Yes No	Yes No	Seizures/epilepsy/etc.	Yes No	Yes No
Autism/Aspergers/DevelopmentalDisorder	Yes No	Yes No	Strokes/Transient ischemic attack	Yes No	Yes No
Depression	Yes No	Yes No	Alzheimer's/dementia	Yes No	Yes No
Bipolar Disorder (manic depression)	Yes No	Yes No	Sleep problems/apnea	Yes No	Yes No
Anxiety	Yes No	Yes No	Headaches (migraine/tension/cluster)	Yes No	Yes No
Schizophrenia/Psychosis	Yes No	Yes No	Genetic disorders	Yes No	Yes No
Behavior/conduct problems	Yes No	Yes No	Other neurological conditions	Yes No	Yes No
Alcoholism	Yes No	Yes No	Heart disease	Yes No	Yes No
Other substance abuse	Yes No	Yes No	Cancer	Yes No	Yes No
Other:	Yes No	Yes No	Other:	Yes No	Yes No

Please provide any additional details about the above or other conditions which run in either biological side of the family or any concerns you may have about any of them developing in your child.

PRIOR ASSESSMENTS

Has your child had any previous assessments?

Type of previous assessments	Yes No	Place	Date
Medical	Yes No		
Audiological	Yes No		
Speech and/or Language	Yes No		
Educational	Yes No		
Psychological	Yes No		
Psychiatric	Yes No		
Other	Yes No		

Please provide copies of reports of past assessments. If they are not available, please describe any significant results from previous assessments or provide other general comments.

OTHER INFORMATION

If there is any other information that is important for us to know to get a good understanding of your child, please explain: