CENTRAL MICHIGAN UNIVERSITY
Central Autism Assessment and Treatment Center

CHILD HISTORY FORM

Please complete **all** information below:

SECTION I: CHILD INFORMATION

MRN:		Office Use Only
CHILD'S NAME		
CHILD'S AGE	BIRTH DATE	SEX
CHILD'S ADDRESS		
PARENT 1 NAME	PRIMARY PHONE	SECONDARY PHONE
ADDRESS (IF DIFFERENT FROM CHILD)		
EMAIL ADDRESS		
PARENT 2 NAME	PRIMARY PHONE	SECONDARY PHONE
ADDRESS (IF DIFFERENT FROM CHILD)		
EMAIL ADDRESS		
PRIMARY CARE PHYSICIAN	OFFICE PHONE	DATE OF LAST VISIT
ADDRESS		
PERSON COMPLETING FORM		PHONE
RELATIONSHIP TO CHILD		DATE FORM COMPLETED
WHO REFERRED THIS CHILD?		
ADDRESS		

SECTION I: CHILD INFORMATION (Continued)

PLEASE DESCRIBE THE REASON FOR THIS EVALUATION:

PLEASE DESCRIBE THE TOP 3 CONCERNS YOU HAVE FOR YOUR CHILD:

1.

2.

3.

DOES YOUR CHILD DEMONSTRATE ANY OF THE FOLLOWING?
CHECK ALL THAT APPLY.

___Alcohol/Drug/Tobacco Use
___Anger/Irritability
___Attention/Concentration
___Bizarre thoughts
___Bullying
___Defiance
___Delays in development
___Eating problems
___Episodic increases in energy
___Excessive worries/fears
___Feeling hopeless/guilty
___Hallucinations
___Harm to self
___Harm to others
___History of trauma
___Inflated self-confidence
___Lying
___Nightmares
___Panic attacks
___Physical complaints
___Problems in the classroom
___Problems with friends
___Property destruction
___Repetitive movements or sounds
___Repetitive thoughts or actions
___Sadness/crying
___School avoidance
___Sensory issues
___Sleep problems
___Snoring
___Speech problems
___Tantrums
___Tics
___Theft
___Unable to enjoy activities

SECTION II: SOCIAL HISTORY

CHILD LIVES WITH:	
THIS IS THE CHILD'S: ___Biological family ___Adoptive family ___Foster Family	
PARENT 1:	
Birthdate:	Age:
Highest Grade:	Occupation:
PARENT 2:	
Birthdate:	Age:
Highest Grade:	Occupation:
OTHER CAREGIVER:	Relationship to Child:
Birthdate:	Age:
Highest Grade:	Occupation:
OTHER CAREGIVER:	Relationship to Child:
Birthdate:	Age:
Highest Grade:	Occupation:
PARENTS ARE (please check one): ___ Married ___Divorced ___Separated ___Never married	
SIBLINGS/AGES:	
PLEASE CHECK ANY SITUATIONS YOUR CHILD HAS EXPERIENCED IN THE LAST YEAR: ___Death of family member ___Major health change of family member ___New family member ___Parents' separation ___Parents' divorce ___Parents' marriage ___Moving to a new location ___Change in parent employment ___Domestic violence	
PLEASE CHECK ANY OF THE FOLLOWING SITUATIONS YOUR CHILD HAS EXPERIENCED: ___Physical abuse ___Sexual abuse ___Legal problems/arrest ___CPS/Foster placement	

SECTION III: MEDICAL HISTORY

PLEASE CHECK IF YOUR CHILD HAS HAD ANY OF THE FOLLOWING:

___Allergies: Food	___Encephalitis	___Mumps
___Allergies: Medication	___Endocrine Disorders	___Muscle Disorders
___Allergies: Seasonal	___Headaches	___Pneumonia
___Anemia	___Head Injury	___Polio
___Arthritis	___Hearing Problems	___Respiratory Problems
___Asthma	___Heart Problems	___Seizures
___Chicken Pox	___High Blood Pressure	___Thyroid Problems
___Constipation	___Kidney Problems	___Tonsillitis
___Diabetes	___Measles	___Vision Problems
___Ear Infections	___Meningitis	___Other:

ARE IMMUNIZATIONS UP TO DATE? ___YES ___NO

DOES YOUR CHILD TAKE ANY MEDICATIONS? ___YES ___NO

If yes, please list medication information below.

MEDICATION NAME:	DOSE:	REASON:

PREVIOUS TESTING:	WHEN/WHERE:	RESULTS:

PREVIOUS SURGERIES/ HOSPITALIZATIONS:	DATE:	REASON:

PLEASE DESCRIBE YOUR CHILD’S SLEEP:

PLEASE DESCRIBE YOUR CHILD’S EATING HABITS:

SECTION IV: PREGNANCY AND DELIVERY HISTORY

LENGTH OF PREGNANCY (in weeks):	BIRTH WEIGHT:	APGAR SCORE:

DELIVERY:
___Elective C-Section ___Emergency C-Section ___Induced Vaginal ___Spontaneous Vaginal

PLEASE CHECK ANY PRENATAL EXPOSURE:

___Alcohol If yes, amount and how long:

___Medication If yes, name and reason:

___Tobacco If yes, amount and how long:

___Illicit Drugs If yes, please specify:

PLEASE CHECK ANY COMPLICATIONS DURING PREGNANCY OR DELIVERY:

___Blood pressure problems	___Maternal fever	___Trauma
___Infections/Rash	___Premature labor	___Vaginal bleeding
___Gestational diabetes	___Seizures	___Other:

PLEASE CHECK ANY OF THE FOLLOWING THAT WERE PRESENT AT BIRTH:

___Apnea	___Feeding problems	___Oxygen therapy
___Breathing problems	___Heart problems	___Seizures
___Congenital abnormalities	___Infection	___Other:
___Cyanosis (blue color)	___Jaundice (yellow color)	

SECTION V: DEVELOPMENTAL HISTORY

PLEASE DESCRIBE ANY DEVELOPMENTAL CONCERNS:

PLEASE INDICATE AT WHAT AGE YOUR CHILD REACHED THE FOLLOWING:

______Smile
______Babble
______Say first word
______Put 2 words together
______Know first name
______Print name
______Sit up alone
______Crawl
______Walk
______Kick a ball
______Bladder trained
______Bowel trained
______Tie shoes
______Puberty

PLEASE CHECK ANY OF THE FOLLOWING WHICH DESCRIBE YOUR CHILD:

___Affectionate
___Competitive
___Cooperative
___Even tempered
___Follower
___Friendly
___Happy
___Hard to discipline
___Has temper tantrums
___Independent
___Leader
___Moody
___Plays in groups
___Plays individually
___Prefers to be alone
___Quiet
___Sad
___Sucks thumb
___Trouble sleeping
___Usually fearful
___Very active

PLEASE LIST DISORDERS WITH WHICH YOUR CHILD HAS BEEN DIAGNOSED:

Diagnosis	Provided by (list provider)	Date

PLEASE CHECK ANY SPECIAL EQUIPMENT YOUR CHILD REQUIRES:

___Communication Device
___Feeding tube
___Glasses
___Hearing aid
___Wheelchair
___Other:

SECTION VI: SPEECH AND LANGUAGE HISTORY

PLEASE DESCRIBE YOUR CHILD'S CURRENT SPEECH:

PLEASE DESCRIBE ANY CONCERNS YOU HAVE ABOUT YOUR CHILD'S SPEECH:

HAS YOUR CHILD RECEIVED ANY HELP WITH SPEECH? If yes, please describe:

HOW MUCH OF THE CHILD'S SPEECH CAN:

Family understand?		Friends understand?		Strangers understand?	
___All	___Most	___All	___Most	___All	___Most
___Some	___None	___Some	___None	___Some	___None

PLEASE CHECK ANY OF THE FOLLOWING WHICH DESCRIBE YOUR CHILD'S SPEECH:

___Appropriate volume	___Appropriate tone	___Flat pitch
___Very soft	___Appropriate pitch	___Other:
___Very loud	___Sing-song pitch	

PLEASE CHECK THE ITEMS WHICH DESCRIBE YOUR CHILD:

___Cried excessively	___Sings songs	___Uses sign language
___Enjoys talking	___Stutters/stammers	___Made pleasure sounds during infancy
___Says nursery rhymes	___Uses gestures	

DID YOUR CHILD'S SPEECH OR SPEECH LEARNING EVER STOP FOR A PERIOD OF TIME?
If yes, when:

SECTION VII: EDUCATIONAL HISTORY

NAME OF CURRENT SCHOOL:

CURRENT GRADE:

PREVIOUS SCHOOLS YOUR CHILD HAS ATTENDED:

	SCHOOL NAME	DATES ATTENDED	GRADES COMPLETED
PRESCHOOL			
ELEMENTARY			
MIDDLE SCHOOL			
HIGH SCHOOL			

HAS YOUR CHILD EVER SKIPPED A GRADE? If yes, when:

HAS YOUR CHILD EVER BEEN RETAINED? If yes, when:

HAS YOUR CHILD EVER BEEN SUSPENDED/EXPELLED? If yes, when and why:

HAS YOUR CHILD HAD PSYCHOLOGICAL OR EDUCATIONAL TESTING? ___YES ___NO
If yes, what were the results?

CHECK ANY OF THE FOLLOWING THAT ARE RELEVANT TO YOUR CHILD'S EDUCATION:

___Alternative Education
___Autism Spectrum Disorder
___Cognitive Impairment
___Deaf-Blindness
___Early Childhood Developmental Delay
___Emotional Impairment
___General Education
___Hearing Impairment
___Home Schooled
___Learning Disability
___Occupational Therapy
___Other Health Impairment
___Physical Impairment
___Physical Therapy
___Resource Room
___Severe Multiple Impairment
___Special Education
___Speech and Language Impairment
___Traumatic Brain Injury
___Visual Impairment
___504 Plan
___Other:

DESCRIBE CURRENT ACADEMIC CONCERNS REPORTED BY CHILD'S TEACHERS:

DESCRIBE CURRENT BEHAVIORAL CONCERNS REPORTED BY CHILD'S TEACHERS:

PLEASE LIST A PERSON AT SCHOOL FAMILIAR WITH YOUR CHILD'S PERFORMANCE:

SECTION VIII: FAMILY HISTORY

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT ARE OR HAVE BEEN PRESENT IN THE CHILD'S **BIOLOGICAL** FAMILY:					
	SIBLINGS	MOTHER	FATHER	MOTHER'S RELATIVES	FATHER'S RELATIVES
ADHD					
Abuse or Neglect					
Alcoholism					
Anxiety					
Autism					
Blindness					
Cancer					
Cerebral Palsy					
Communication Disorder					
Deafness					
Dementia/Alzheimer's					
Depression					
Developmental Delay					
Diabetes					
Drug use/abuse					
Encopresis (soiling)					
Enuresis (bedwetting)					
Genetic Disorder					
HIV or AIDS					
Heart Disease					
High Blood Pressure					
History of Harming Self					
History of Harming Others					
History of Psychiatric Hospitalization					
Intellectual Disability					
Learning Disability					
Legal Problems					
Mania or Bipolar					
Migraine Headaches					
Obesity					
OCD					
Psychosis or Schizophrenia					
Seizures					
Sleep Disorder					
Special Education					
Suicide					
Tics/Tourette's					
Use of Psychiatric Medication					

SECTION IX: ADDITIONAL INFORMATION

Please list any additional information that might be helpful in the evaluation.

____

Parent/Guardian Signature Date

Printed Name Relationship to Client