HAWAII CENTER *for* PSYCHOLOGY

HAWAII CENTER *for* ACADEMIC ASSESSMENT
A division of Hawaii Center for Psychology

Assessment Services: Child History Form

Welcome to Hawaii Center for Psychology and Hawaii Center for Academic Assessment!
We appreciate your care in answering *each* question as it allows us to provide the best support for you and your child.

PATIENT INFORMATION

Child's legal name: _____
(First name) (Middle name) (Last name)

Child's preferred name:_____ _____ **Gender:** ❑ Male ❑ Female

Child's birth date: _____ **Ethnicities:**_____

Name of person completing form: ❑ **Mr.** ❑ **Mrs.** ❑ **Ms.** ❑ **Miss** _____

Relationship to child: ❑ **Mother** ❑ **Father** ❑ **Legal-guardian** ❑ **Other:**_____

CONTACT INFORMATION

Please only provide contact numbers where HCP may call to confirm appointments, leave messages via voicemail, or with anyone who answers:

Contact to schedule appointments: _____ _ **Relationship to child:**_____

Contact numbers: 1)_____ **2)** _____

Emergency contact:_____ **Relationship to child:**_____

Contact numbers: 1)_____ **2)** _____

Mailing Address:_____
(Street) (Apt. #)

_____
(City, State) (Zip Code)

REFERRAL CONCERNS

Who referred you for this evaluation? _____

Please describe your concerns:_____

_____

When did you first notice these difficulties?_____

_____

What specific questions would you like answered through this evaluation?_____

_____

_____

_____

Have you addressed these concerns through previous testing and/or services? ❑ No ❑ Yes

Name of professional:_____

Month/Year:_____ **Results/Diagnosis:**_____

What increases or exacerbates these symptoms?_____

_____

What decreases or improves these symptoms? How does your child cope with these stressors?_____

_____

FAMILY HISTORY

Please answer the following questions regarding your CHILD'S BIOLOGICAL MOTHER:

❑ Mrs. ❑ Ms. _____

(Legal First Name) (Legal Last Name)

Current health: ❑ Good ❑ Fair ❑ Poor **Health concerns:**_____

Highest level of education:_____ **Employment title:**_____

Please answer the following questions regarding your CHILD'S BIOLOGICAL FATHER:

_____

(Legal First Name) (Legal Last Name)

Current health: ❑ Good ❑ Fair ❑ Poor **Health concerns:**_____

Highest level of education:_____ **Employment title:**_____

Marital status of child's biological parents:

❑ Never married/In a relationship together ❑ Never married/Single

❑ Married ❑ Separated; Age of child at the time:_____

❑ Widowed; Age of child at the time:_____ ❑ Divorced; Age of child at the time:_____

***If applicable, please share custody arrangement and submit supporting documentation:**

Physical Custody: ❑ Sole ❑ Joint Name of guardian(s):_____

Legal Custody: ❑ Sole ❑ Joint Name of guardian(s): _____

If applicable, please share information regarding other caregivers (e.g., legal guardians, step-parents).

1) Relationship to child: ❑ Legal guardian ❑ Step-parent

❑ Mrs. ❑ Ms. ❑ Mr. _____

(Legal First Name) (Legal Last Name)

Current health: ❑ Good ❑ Fair ❑ Poor **Health concerns:**_____

Highest level of education:_____ **Employment title:**_____

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2) Relationship to child: ❑ Legal guardian ❑ Step-parent

❑ Mrs. ❑ Ms. ❑ Mr. _____

(Legal First Name) (Legal Last Name)

Current health: ❑ Good ❑ Fair ❑ Poor **Health concerns:**_____

Highest level of education:_____ **Employment title:**_____

Was your child adopted? ❑ No ❑ Yes Child's age at time of adoption:_____

Is your child aware of his/her adoption? ❑ No ❑ Yes

Was your child ever in the care of a foster family? ❑ No ❑ Yes; Ages of foster care placement:_____

In whose care was your child in?_____

Child's birth order: ❑ Only-child ❑ Oldest ❑ Youngest ❑ Other:_____

Names and ages of child's siblings (including biological, half-siblings, and step-siblings):

Sisters:_____

Brothers:_____

Place of birth (City, State/Country):_____

List all places of residence (City, State/Country) and dates (month/year):

_____

_____

List all individuals currently living with your child (Name, relationship to child, age):

_____

_____

Primary language:_____ **Secondary language:**_____

DEVELOPMENTAL HISTORY

Please answer the following questions in regard to the CHILD'S BIOLOGICAL MOTHER:

Was prenatal care provided by a physician? ❑ Yes ❑ No; **Describe:**_____

Maternal health during pregnancy: ❑ Good ❑ Fair ❑ Poor **Describe:**_____

Were there any health concerns regarding maternal health? ❑ No ❑ Yes; **Describe:**_____

Were there any health concerns regarding fetal development? ❑ No ❑ Yes; **Describe:**_____

Did mother take medication during pregnancy? ❑ No ❑ Yes; **Describe:**_____

Please check any that may apply if there were either suspected or known exposure to any of the following during pregnancy:

❑ Nicotine (cigarettes) ❑ Alcohol ❑ Cannabis (marijuana) ❑ Amphetamines
❑ Pesticides ❑ Lead ❑ Other:_____

Child was born: ❑ Full-term ❑ Premature* ❑ Late* ***How many weeks?**_____

Delivery: ❑ No complications ❑ Induced ❑ Forceps ❑ Cesarean **Other:**_____

Were there any complications in prenatal history: ❑ No ❑ Yes; Check any that may apply below.

❑ Low birth weight ❑ Poor vital signs ❑ Difficulty breathing
❑ Feeding problems ❑ Sleeping problems ❑ Treatment in Neonatal Intensive Care Unit
❑ Other:_____

During your child's first few years of life, please indicate whether your child was formally evaluated or received services for development in these areas:

❑ Physical development (meeting height/weight milestones) ❑ Motor coordination (crawling, walking)
❑ Speech and language ❑ Self-help (dressing, eating)
❑ Toileting (day, night) ❑ Social/emotional (forming peer relationships)
❑ Other:_____

Name of professional:_____

Month/Year:_____ **Results/Diagnosis:**_____

MEDICAL HISTORY

Physician:_____ **Phone:**_____
(First name) (Last name)

Address:_____

Child's current physical health: ❑ Good ❑ Fair ❑ Poor **Health concerns:**_____

Last medical examination (Month/Year):_____ **Up-to-date on immunizations?** ❑ Yes ❑ No

List ALL medications prescribed to child (PREVIOUS & CURRENT):

Medication	Reason Taken	Dosage/Frequency	Prescribed by	Start/End Dates

Please note medical conditions/events that apply:

- ❑ **Head injuries/concussions**
- ❑ **Surgeries**
- ❑ **Hospitalizations**
- ❑ **Asthma**
- ❑ **Loss of consciousness**
- ❑ **Illnesses**
- ❑ **Seizures**
- ❑ **Allergies**

Please describe:

_____

_____

EDUCATIONAL HISTORY

Current school:_____ **Current grade level:**_____

Grades child has attended school:_____

Our comprehensive evaluations often include obtaining feedback from an individual at your child's school to assist in formulating helpful school recommendations in our report. Please provide the name of one individual who is CURRENTLY instructing or working closely with your child. We will ALWAYS obtain your consent prior to contacting this individual.

Position: ❑ Teacher ❑ Counselor ❑ Other:_____

❑ Mrs. ❑ Ms. ❑ Mr. _____

(First Name) (Last Name)

Please list other schools & grades attended:

_____

_____

Has your child ever repeated any grades? ❑ No ❑ Yes If yes, which grade(s)?_____

Reason:_____

What are your child's strongest subjects:_____

What are your child's most challenging subjects:_____

Please check any that apply:

Diagnosed: ❑ Reading Disorder (Dyslexia) ❑ Writing Disorder (Dysgraphia) ❑ Mathematics Disorder (Dyscalculia)

Qualified for services under: ❑ Section 504 ❑ Individualized Education Program

Received academic accommodations: ❑ No ❑ Yes If yes, please describe:_____

_____

_____