



Hands On Learning Solutions

Confidential Personal History

Today's Date: _____ Completed by: _____

Last Name: _____ Child's Name: _____

Birth Date: _____ Age: _____ Gender: _____

School: _____ Grade in School: _____

Teacher's Name: _____ Type of Classroom: _____

Family

Marital Status of Parents: ___Married ___Separated ___Divorced ___Other

Parent Name: _____ **Parent Name:** _____

Mr. Mrs. Ms.

Mr. Mrs. Ms.

Address: _____ Address: _____

City, State Zip: _____ City, State Zip: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Work Phone: _____ Work Phone: _____

Family E-mail: _____

Other children in the family: (name, age)

Medical

Date of Child's Last Medical Checkup: _____

Does your child currently take any medications? Yes ___ No ___

If yes, what medications and for what reason? _____

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Has your child been diagnosed with:

	Diagnosed by	Criteria / Scores
<input type="checkbox"/> ADD	_____	_____
<input type="checkbox"/> ADHD	_____	_____
<input type="checkbox"/> Anxiety Disorder	_____	_____
<input type="checkbox"/> Autistic Spectrum Disorder	_____	_____
<input type="checkbox"/> Cognitive Delay	_____	_____
<input type="checkbox"/> Down Syndrome	_____	_____
<input type="checkbox"/> Dyslexia	_____	_____
<input type="checkbox"/> Sensory Processing Disorder	_____	_____
<input type="checkbox"/> Tourette's Syndrome	_____	_____
<input type="checkbox"/> Mood Disorder: _____	_____	_____
<input type="checkbox"/> Emotional Disorder: _____	_____	_____
<input type="checkbox"/> Learning Disability: _____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____

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

Personality

What are your child's gifts / strengths? _____

What do you enjoy most about your child and family?

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Presenting Problems (All categories below may not apply.)

Academic: _____

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

Relationships: _____

Sensory: _____

Motor: _____

Play: _____

Other: _____

Interests and Activities (hobbies, sports, clubs)

Please list them in order of preference beginning with the favorite activity.

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Family Adaptations

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 _____

Mother _____

Siblings _____

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 mother

Were there complications?

shock severe stress loss of a loved one accident
health problems confinement to bed other _____

Yes No Comments

Was mother exposed to loud noises?	_____	_____	_____
Did mother smoke or consume alcohol?	_____	_____	_____
Did mother take any medication? specify	_____	_____	_____
Was mother physically active?	_____	_____	_____
Did mom feel baby kick, what week	_____	_____	_____

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Labor and Delivery

Describe your experience during labor and delivery _____

		<u>Comments</u>
Length of labor?	_____ hrs	_____
Premature: specify	Yes____ No____	_____
Forceps used or 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

Is your child aware of his/her adoption? Yes____ No____ _____

Describe the circumstances surrounding the adoption.

More specifically:

Age when adopted: _____; Prior foster homes: _____

Physical appearance: _____

Response to new home: _____

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Infancy and Toddlerhood

Going back to the **first two years** of the child's life, what type of baby was he/she?

(feeding, sleeping, activity level)

In first two years

Yes No Comments

Breastfed	_____	_____	_____
Extended separations (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	_____	_____	_____
Toe walker (until what age)	_____	_____	_____
Go through "terrible twos"	_____	_____	_____
Describe your child's toddler stage:	_____		

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Childhood Illnesses / Problems

<u>Age</u>	<u>Comments / Deficits</u>
___ respiratory problems	_____
___ high fever	_____
___ strep throat	_____
___ allergies	Specify: _____

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

___ Asthma	_____
___ Skin problems	_____
___ Gastro-Intestinal	_____
___ Seizures	_____
___ Epilepsy	_____
___ Sleep	_____
___ Bedwetting	_____
___ 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? _____

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Developmental Milestones

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

Rolling over _____

Walking _____

Sitting alone _____

Chewing solid food _____

Crawling _____

Drinking from a cup _____

Was crawling phase brief? Yes _____ No _____ Absent? Yes _____ No _____

Did child use a walker (rolling plastic seat)? Yes _____ No _____ If yes, how often? _____

Hesitancy or delays 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?

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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_____

Do you or others have difficulty understanding what 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. confuse 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.

Family History

Any dyslexia in family history? Yes _____ No _____

Did any relatives of client have learning difficulties or disabilities growing up? If so, what kind?

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Other

Does your child have trouble telling time on an analog clock? Yes_____ No_____

What activities does your child find the most fun? _____

What grabs your child's attention and keeps it? _____

What activities calm your child? _____

What activities help your child become more organized? _____

What activities create anxiety in your child? _____

Previous Testing and Treatments

Has your child had any previous assessments or treatment? Yes_____ No_____ *Please attach relevant reports.*

	<u>Yes / No</u>	<u>Where</u>	<u>Date</u>
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)

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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:_____

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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 HOLS? _____

If you were referred:

Referred by: _____ Profession: _____

Address: _____

Hands On Learning Solutions has my permission to send a thank you letter to my referral source indicating the my child has been seen for an evaluation. Yes _____ No _____

Parent or Guardian: _____ Date: _____