Global Naturopath

Child/Adolescent History Form

Today's Date__________
Name: __________________________ Nickname: _________________ DOB: _________
Allergies:____________________

What is the chief health concern? (Give a brief history if other than routine well care):

____
____
____
____
____

FAMILY HISTORY **Name Sex (M/F) Date of Birth Health/Concerns**

Mother:

____
____

Father:

____
____

Siblings:
1.

____
____

2.

____
____

Prenatal History

Complications during pregnancy: ____
Medications: ____
Illnesses: ____
Dental work: ____
Trauma: ____
Location of Birth: ____

Birth & Neonatal Period

Duration of Pregnancy: Term: (37-42 wks)_______________ Premature (<37 wks):_________________
Post mature (>42wks) _______
Labor: Duration: ____________________________ Complications: _______________________________
Delivery: Vaginal: _________ C-Section:_________ Breech: _________ Forceps:_______
Other:_______
Condition at Birth: __________________________________

Apgars (if known): 1-min_________ 5-min_________
Birth Weight: ____________________ Birth Length: ____________________

Any cyanosis/(blue) or jaundice/(yellow) ___Yes ___No

Any feeding problems? __________ Breast_____ Formula (type)_____ Vitamins_____

Age started foods?_____

Health in first month: ____________________________

Developmental Landmarks: (list age)

___________Sat Up by Self __________________First Words __________________Bladder Training
___________Stood Holding On _______________Short Sentences ______________Bowel Training
___________Rolled Over (back-to-front) ________First Tooth ___________________Walked Well

Early Childhood History

During this child's first three years, were any special problems noted in the following areas?

- ☐ Irritability
- ☐ Difficulty sleeping
- ☐ Failure to thrive
- ☐ Poor eye contact
- ☐ Convulsions/Seizures
- ☐ Other
- ☐ Breathing problems
- ☐ Eating problems
- ☐ Excessive crying
- ☐ Early learning problems
- ☐ Twitching
- ☐ Colic
- ☐ Temper tantrums
- ☐ Withdrawn behavior
- ☐ Destructive behavior
- ☐ Unable to separate from parent

Language development

Indicate age when child begin babbling, such as repeating syllables, in attempts to communicate:

Using single words?____

Using phrases/short sentences?____

Have there been any hearing concerns? ☐ No ☐ Yes

Hearing testing done ____________

Development Milestones of Child

CHECKLIST: Please mark any of the following in each area that describe your child's currently or in the past:

Speech

Past	Current	
☐	☐	slow speech development
☐	☐	doesn't understand without gestures
☐	☐	unusual tone or pitch
☐	☐	repeats words/phrases over and over
☐	☐	difficult to understand speech
☐	☐	repeats questions, instead of answering them
☐	☐	seldom speaks unless prompted
☐	☐	repeats dialogue from movies/songs verbatim
☐	☐	has language of his/her own (may sound like foreign language/jargon)

Additional Comments____

Relating with other people

Past	Current	
☐	☐	prefers to be by self
☐	☐	"in a world of his/her own"
☐	☐	aloof, distant
☐	☐	clings to people
☐	☐	fearful of strangers
☐	☐	not cuddly as baby
☐	☐	doesn't like to be held
☐	☐	doesn't recognize parent
☐	☐	doesn't play with other children
☐	☐	prefers playing with younger or older children

Additional Comments____

Imitation

Past	Current	
☐	☐	doesn't imitate waving "bye-bye" or "patty cake" etc. (physical imitation)
☐	☐	doesn't repeat words/things said to him
☐	☐	doesn't repeat words generally, but usually did what he was asked to do

Response to Sounds, Speech

Past	Current	
☐	☐	often ignores sounds
☐	☐	often ignores what is said to him/her
☐	☐	afraid of certain sounds
☐	☐	really likes certain sounds (music, motors, etc.)
☐	☐	seems to hear distant/soft sounds that most people don't hear/notice
☐	☐	unpredictable response to sounds (sometimes reacts, sometimes doesn't)
☐	☐	responds to speech and sounds like other children of the same age

Additional Comments____

Visual Response

Past	Current	
☐	☐	stares vacantly around room
☐	☐	plays with turning lights on and off
☐	☐	often doesn't look at things
☐	☐	distracted by lights – stares at certain lights
☐	☐	likes to look at self in mirror
☐	☐	very interested in small parts of an object
☐	☐	likes to look at shiny objects
☐	☐	looks at things out of the corners of eyes
☐	☐	stares at parts of his/her body (e.g. hands)
☐	☐	often avoids looking at people when they are talking to him

Additional Comments____

Other Senses

Past	Current	
☐	☐	puts many objects in mouth
☐	☐	likes vibrations
☐	☐	licks objects

☐ ☐ doesn't notice pain as much as most people
☐ ☐ overreacts to pain
☐ ☐ smells objects unusual or unfamiliar objects
☐ ☐ chews or eats objects that are not supposed to be eaten
Additional Comments____

Emotional Responses

Past Current
☐ ☐ temper tantrums
☐ ☐ laughs/smiles for no obvious reason
☐ ☐ overly responds to situations
☐ ☐ moods change quickly/for no apparent reason
☐ ☐ cries/seems sad for no obvious reason
☐ ☐ often has blank expression on face
☐ ☐ little response to what is happening around him/her
Additional Comments____

Adaptive Skills

Feeds self	☐ No	☐ Yes, beginning at age _______
Dresses self	☐No	☐ Yes, beginning at age _______
Bathes self	☐ No	☐ Yes, beginning at age _______
Helps with household chores	☐ No	☐ Yes, beginning at age _______
Knows first and last name	☐ No	☐ Yes, beginning at age _______
Says "please" and "thank you"	☐ No	☐ Yes, beginning at age _______
Able to walk up/down stairs	☐ No	☐ Yes, beginning at age _______

Has the child ever lost skills, which at one time he/she was able to perform? ☐ No ☐ Yes
If yes, please explain____

When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?
☐ Time out ☐ Loss of allowance/privileges ☐ Physical punishment ☐ Yelling
☐ Ignoring ☐ Grounding ☐ Other, describe

Who is mainly in charge of discipline?____

What do you find most difficult about raising your child?________________________________

School History and Performance

(If more space is necessary, please attach additional sheets or write on the back of this page.) This is very useful Information, as all pieces fit together to make children with Autism Successful. As SPAN Advocate, will also assist parents, in areas that need to be addressed.

Early Childhood Intervention (ECI)

Is your child currently a client of ECI? ☐ Yes ☐ No (If No skip the section)
Which ECI Center: ____
Eligibility category:____
Child's age when ECI services began:____

Preschool and Above

Current school:____________________________School district:______________________________

Grade level:____

Type of class: ☐ Regular Ed ☐ Special Ed ☐ Resource ☐ ED ☐ Behavioral unit

Current # of: Students _______Teachers _______ Aides ________ Does your child have a 1:1 Aide?
Present Grades in School: ________________Good _______________Average ______________Poor

School Behavior Problems:
____
Special Educational Needs:
____
Describe Relationship with Friends/Peers?
____
Favorite Activities: ____ Least Favorite Activities: _____________________

Has your child had special education testing in school?

- ☐ Psychological/Cognitive – Date: ____
- ☐ Academic – Date: ____
- ☐ Speech/Language – Date: ____
- ☐ Other: ___________________ Date: _________

Is your child receiving any special education services at school? ____________Yes ____________No

Does your child have an IEP (Individual Education Plan)? _____________________________________

Please list all of the schools, including preschools, your child has attended. (Name of school Age/grade attended, ABA Hours per day Days per week in school)

____
____
____
____
____

Educational Services - Please list services your child has received.
Child's age when school services began:____
Individual Education Plan (IEP) eligibility:____

Which services is your child CURRENTLY receiving through the SCHOOL DISTRICT?

- ☐ Speech therapy
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Adaptive Physical Education
- ☐ Discrete Trial Training (DTT/ABA)
- ☐ Social Skills
- ☐ Other - describe:

Which services is your child CURRENTLY receiving through the REGIONAL CENTER?

- ☐ Speech therapy
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Adaptive Physical Education
- ☐ Discrete Trial Training (DTT/ABA)
- ☐ Social Skills
- ☐ Other - describe:

Generally Preferred Medical Treatments

Prescription Medications	_____Yes	_____No
Natural Medications (herbs)	_____Yes	_____No
Homeopathic Remedies	_____Yes	_____No
Acupuncture	_____Yes	_____No
Chiropractic	_____Yes	_____No
Naturopathic	_____Yes	_____No

Is your child currently taking any form of medication, herbs, homeopathic, vitamins or minerals?
_____Yes _____No
If Yes, Describe:
____
____
____
____
____

Diet Information: (check which applies) Child Family in General
Traditional American Diet ____
Macrobiotic ____
Vegetarian ____
Vegetarian with **(circle)** Cheese/Egg/Poultry/Fish __________________________________
Vegan ____
Other ____
Food Intolerances ____
Describe Additional Diets Child is on/was on, Success and Comments
____
____
____

Medication history

Current Medications (PLEASE NOTE: DO ADMINISTER child's regularly scheduled medications, if any, on the day of your appointment.)
Name of medication Dose & Frequency____
Date Started____
Reason and Effectiveness____
Who prescribes these medications? ____
Date of last visit____

Family Medical History: (parents, grandparents, siblings)

Who
Abuse ______________________________
Alcoholism__________________________
Allergies____________________________
Arthritis ____________________________
Asthma _____________________________
Autoimmune Disease___________________
Birth Defects_________________________
Bleeding Disorder______________________
Cancer ______________________________
DES exposure__________________________
Diabetes _____________________________
Drug Abuse___________________________
Other_________________________________
Eczema ______________________________
Epilepsy/Seizures ______________________
Gastrointestinal Disease _________________
Hearing Loss __________________________
Heart Attack (under 50) __________________
High Cholesterol _______________________
Migraines ____________________________
Psychological Illnesses__________________
Smoking _____________________________
Sudden Infant Death____________________
Thyroid Disease _______________________
Father's Blood Type: __________ RH:_______ Mother's Blood Type:___________ RH:_____________

Risk Assessment: Explain

Do all family members use seatbelts all the time?
____
Does child use a bike helmet?
____

Any smokers in the house?
____
Any family history of alcohol excess or drug use?
____
Any firearms in the house?
____
Any family history of abuse in either parent's family?
____

Adolescence: (Do you believe your adolescent may have had:)

History of Drug Use? _____Past _____Present
History of Alcohol Intake? _____Past _____Present
History of Smoking? ____ _____Past _____Present
History of Abuse? _____Past _____Present
History of Eating Problems? _____Past _____Present
History of Sharing Needles? _____Past _____Present
History of Sexual Intercourse? _____Past _____Present
Do you have other concerns? (Please list)
____