Compressive Diagnostic Assessment / Pediatric History

Child's Name:_____ Date of Assessment: _____
Child's DOB:_____ Guardian Present:_____
Evaluator: _____ Relationship to child (e.g., mother): _____
Members present during follow-up: _____ Relationship: _____
_____ Relationship: _____

Has the child been seen by Dr. Faraday (Previously Dr. Lawson) in the past? ☐ Yes ☐ No

Was the child's **sibling** ever seen by Dr. Faraday (Previously Dr. Lawson)? ☐ Yes ☐ No
If *Yes*, name? _____

Referral Information
Who referred you (Name & Agency/Clinic)? _____
Who is the child' primary care physician/pediatrician (Name & Clinic)? _____

Is your child under the care of other medical providers or specialists (e.g., psychiatrist, neurologist? ☐ Yes ☐ No
If *Yes*, for what? _____ Name of Provider _____
_____ _____
_____ _____
_____ _____
_____ _____

Treatment
Please check ALL service/interventions that your child is **currently** enrolled in:
☐ None
☐ Therapy/counseling
☐ Social skills class
☐ Parenting class
☐ Residential treatment
☐ Community-Based Rehabilitative Services (CBRS) / *Formally* Psychosocial Rehabilitation (PSR)
☐ Case Management / *Formally* Service Coordination
☐ Developmental disability services (e.g., Habilitative Intervention, Habilitative Supports, IBI, DT)
☐ Speech / language Therapy
☐ Occupational therapy (OT)
☐ Physical therapy (PT)
☐ Other: _____

How is your child progressing through his/her therapies? _____
_____

Educational History
Name of child's current school: _____ Grade: _____
** If summer, what grade next term?*
Is your child struggling academically ☐ Yes ☐ No
If *Yes*, which subject(s) or identify other problems (e.g., following through with assignments/homework, etc.):
_____
_____
_____
Are there any concerns for a possible learning disability (i.e., dyslexia or reading disorder, math or writing disorder)?
☐ Yes ☐ No

Are you wanting additional academic testing? ☐ Yes ☐ No *(let them know it will be an out-of-pocket expense)*

Present Class Placement: ☐ Regular classroom
☐ Individualized Education Plan (IEP)
☐ Aide
☐ 504 Plan
☐ Title 1
☐ Bilingual/ESL services
☐ Gifted / talented services
☐ Other (**specify**): _____

Prenatal Period

Did the mother have any of the following during or immediately before/after the pregnancy?

☐ Emotional stress	☐ Serious Infection	☐ Preterm labor
☐ Toxemia	☐ Anemia	☐ Excessive weight gain
☐ Preeclampsia	☐ Measles/German measles	☐ Kidney disease
☐ High blood pressure	☐ Serious illness: _____	☐ Maternal injury
☐ Vaginal bleeding	☐ Strep throat	☐ Threatened miscarriage
☐ Excessive swelling	☐ Epilepsy/seizure	☐ High fever
☐ Rh incompatibility	☐ Diabetes	☐ Excessive Nausea OR ☐ vomiting

☐ Operation or hospitalization during pregnancy: (**specify**): _____
☐ Other (**specify**): _____

Were any of the following used by the mother during pregnancy?

☐ Tobacco	☐ Marijuana	☐ Methadone
☐ Alcohol	☐ Heroin	
☐ Amphetamines	☐ Methamphetamines	

☐ Prescribed medications (**specify**):_____
☐ Others (**specify**):_____

Any health concerns, medications, or substances used (e.g. tobacco, alcohol, drug use) on the part of the **father** near or shortly before the time of conception? ☐ Yes ☐ No
If *Yes*, please specify: _____
_____

Birth & Developmental History

Was infant born full term? ☐ Yes ☐ No
Number of weeks gestation: _____ Birth Weight? _____ lbs. _____ oz.

Type of Birth? ☐ Vaginal ☐ C/Section. If C/Section, was it:
Planned ☐ Yes ☐ No Emergency ☐ Yes ☐ No

Please indicate the following problems that may have occurred during labor:

☐ Toxemia	☐ Fetal distress
☐ Eclampsia	☐ Vacuum suction
☐ Maternal fever	☐ Use of forceps

☐ Maternal medications used (**specify**): _____

Describe any other complications during labor or delivery: _____
_____

Did any of the following problems occur within the first few **days** after the child's birth?

☐ Trouble breathing
☐ Cord around the neck (# of times _____)
☐ Cardiopulmonary (heart/lung) distress
☐ Knot in cord
☐ Seizures
☐ Hemorrhage (bleeding) in head
☐ Hydrocephalus (water on the brain)
☐ Cyanosis (turned blue)
☐ Need for ventilation
☐ Required oxygen
☐ Required resuscitation
☐ Required NICU (how long? _____)
☐ Jaundice
☐ Poor feeding
☐ Required medication
☐ Required a blood transfusion
☐ Vomiting / ☐ Reflux
☐ Floppy muscle tone
☐ Required incubator care
☐ Infection
☐ Fever
☐ Injury during delivery: _____
☐ Born with congenital defect: _____

Length of stay in hospital: Mother: _____ days Infant: _____ days.

As an infant and toddler

Was your child… ☐ Easy to please OR ☐ Difficult/Fussy
Was your child interested in social contact? ☐ Yes ☐ No
Did he or she make eye contact? ☐ Yes ☐ No
Did your child share affection? ☐ Yes ☐ No
Did he or she struggle with change? ☐ Yes ☐ No
Other (**specify**): _____

Were developmental **motor** milestones achieved ON time? ☐ Yes ☐ No
Were developmental **language** milestones achieved ON time? ☐ Yes ☐ No
Were there any early learning problems? ☐ Yes ☐ No

Any current toileting concerns (e.g., daytime wetting/soiling accidents, bedwetting?) ☐ Yes ☐ No
If *Yes*, explain: _____

Medical/Mental Health History

Has your child been OFFICIALLY given any of the following diagnoses?
***If any diagnosis is under consideration, indicate with (UC)*

☐ Epilepsy / seizure disorder
☐ Autism / ☐ Asperger's / ☐ PDD
☐ Thyroid disorder
☐ Blood disorder
☐ Asthma
☐ Childhood disease:_____
☐ Tourette's / tic disorder
☐ Cancer
☐ Intellectual disability (MR)
☐ Diabetes
☐ Fragile X
☐ Developmental delay
☐ Learning disability
☐ Language disorder
☐ Traumatic brain injury
☐ High blood pressure
☐ Anxiety disorder
☐ Depression
☐ Bipolar disorder
☐ Schizophrenia
☐ Conduct disorder
☐ Oppositional defiant dis.
☐ Attention-deficit (ADHD)
☐ Genetic disorder (**specify**): _____
☐ Other (**specify**): _____

Does the child have any allergies (e.g., food, medications, etc.)? ☐ Yes ☐ No
If *Yes*, specify: _____

Medications: ☐ Yes ☐ No If *Yes*, list below:

Current Medication(s)	Prescriber/Specialty	Reason for Taking

Appetite concerns? ☐ Normal ☐ Picky ☐ Eats too much ☐ Weight Loss ☐ Weight Gain
Please specify other concerns with eating: _____
_____

Does your child normally get a well-balanced and healthy meal? ☐ Yes ☐ No

Oral Motor Concerns? ☐ None ☐ Difficulty swallowing ☐ Drooling ☐ Gagging

Does your child have problems falling asleep? ☐ Yes ☐ No
If *Yes*, how long does it take for him/her to fall asleep? _____ hours

Does your child wake up in the middle of the night? ☐ Yes ☐ No
If *Yes*, typically how many times per night? _____

How many hours does your child currently sleep at night? _____

Has your child ever been unconscious? ☐ Yes ☐ No If *Yes*, age:_____ and situation: _____
_____
_____

Surgeries: Age: _____ Reason: _____ Where: _____
Other details: _____

Hospitalizations: Age: _____ Reason: _____ Where: _____
Other details: _____

Psychiatric Hospitalizations: Age: _____ Reason: _____
Where: _____ Other details: _____

Major accidents or injuries: Age: _____ Reason: _____ Where: _____
Other details: _____

Does your child have (or had) any of the following problems?
***If no longer problematic, please indicate by (P)*

☐ Chronic earaches/infections
☐ Ear tubes
☐ Hearing problems
☐ Wears hearing aid in R / L ear
☐ Vision problems
☐ Crossed eyes
☐ Wears glasses
☐ Meningitis
☐ Encephalitis
☐ Drug intoxication
☐ Poisoning
☐ Other (**specify**): _____
☐ Frequent stomachaches
☐ Frequent vomiting
☐ Constipation
☐ Urine infections
☐ Endocrine / gland problems
☐ Immune system disorders
☐ Growth problems
☐ Excessive bleeding or bruising
☐ Frequent and/or severe headaches
☐ Tremors or twitches (**specify**):_____
☐ High fevers (over 103)

Has your child had ANY of the following tests or evaluations?

☐ CT Scan of Head Results: _____
☐ MRI Scan of Head Results: _____
☐ EEG Results: _____
☐ Audiology/Hearing Results: _____
☐ Vision Evaluation Results: _____
☐ Genetic Testing Results: _____
☐ Metabolic Testing Results: _____
☐ Blood tests Results: _____

☐ Neurology Results: _____
☐ Neuropsychology Results: _____
☐ Psychiatry Results: _____
☐ Psychology Results: _____

Family Medical/Mental Health History

Please indicate if any of the child's family members have/had the following problems/disorders:

☐ Birth defect: _____
☐ Genetic disorder: _____
☐ Cerebral palsy
☐ Severe head injury
☐ Migraine headaches
☐ Multiple sclerosis
☐ Physical disability: _____
☐ Tuberous sclerosis
☐ Huntington's chorea
☐ Muscular dystrophy
☐ Sickle-cell anemia
☐ Seizures or epilepsy
☐ Cancer
☐ Diabetes
☐ Heart disease
☐ Alcohol / ☐ Drug Abuse
☐ Physical / ☐ Sexual Abuse

☐ Learning problems: _____
☐ Speech / language challenges
☐ Developmental delay
☐ Motor coordination difficulty
☐ Intellectual disability (MR)
☐ Autism / ☐ Asperger's / ☐ PDD
☐ Attention-deficit
☐ Oppositional / defiant behaviors
☐ Aggression
☐ Poor social skills
☐ Tics / Tourette's disorder
☐ Anxiety
☐ Obsessive-compulsive disorder
☐ Depression
☐ Bipolar disorder
☐ Schizophrenia
☐ Other: _____

Neurocognitive History & Presenting Concerns

Language ☐ *No concerns* ☐ *Nonverbal* *(see below)

When focused, does your child have problems with: ☐ vocabulary ☐ expressing him/herself ☐ understanding others ☐ speech/articulation problems ☐ stuttering ☐ mixing up words/letters ☐ word-finding difficulty ☐ sustaining/maintaining conversation ☐ understanding body language ☐ using appropriate gestures ☐ dominating conversation ☐ changing topic of conversation ☐ makes comments *out of the blue* ☐ talks excessively ☐ interrupts others

Children with very limited language

Does your child babble? ☐ Yes ☐ No
Does your child use word-approximations? ☐ Yes ☐ No
Can your child following simple or one-step instruction? ☐ Yes ☐ No
Does your child gesture or point? ☐ Yes ☐ No
Estimated vocabulary: _____

Learning/Memory ☐ *No concerns*

Does your child have any problems with: ☐ retaining new information ☐ processing information ☐ comprehending information ☐ logic ☐ reasoning ☐ understanding cause & effect sequences ☐ requires extra time studying ☐ requires frequent repetition of material ☐ short-term recall ☐ long-term recall ☐ is forgetful ☐ often loses or misplaces things

Attention/Focus/Executive ☐ *No concerns*

Which of the following are present: ☐ inattention ☐ listening to others ☐ sustaining attention for long periods of time ☐ following multistep/complex instruction ☐ efficiency ☐ needs frequent redirection ☐ staying on task ☐ starting tasks ☐ organizing ☐ planning ☐ problem-solving ☐ impulsivity ☐ impatient ☐ makes poor decisions ☐ lacks insight

Are attention/focus/executive symptoms present at school? ☐ Yes ☐ No

Sensory-Motor ☐ *No concerns*

Which of the following are present? ☐ poor penmanship ☐ problems with using - pls circle: utensils / buttoning /zipping / tying shoes ☐ poor balance ☐ poor coordination ☐ clumsy ☐ doesn't pay attention to things around him/her ☐ weak muscle tone ☐ irritated/bothered by - pls circle: loud noise / bright lights / textures of clothing / food textures / certain smells ☐ prone to sensory over-load ☐ likes to be squeezed/bundled up ☐ other _____

Which of the following are present? ☐ hyperactivity ☐ is *on the go* as driven by motor ☐ can't sit or remain still for short periods of time ☐ restless ☐ fidgety ☐ excessively picks ☐ easily bored ☐ is excessively slow ☐ complains of being tired/fatigued

Are tics present? ☐ Yes ☐ No If, Yes, describe: _____

Behavior ☐ *No concerns*

Which of the following are present? ☐ lying ☐ breaking rules ☐ destroying property ☐ stealing ☐ disrespect ☐ argumentative ☐ defiant ☐ verbal aggression ☐ physical aggression ☐ hurting animals (with intent) ☐ lacks motivation ☐ often procrastinates ☐ other _____

Is your child prone to outbursts, temper tantrums, melt-downs? ☐ Yes ☐ No, If *Yes*…

What do they look like? _____

_____

What triggers them? _____

_____

How often do they occur? _____ How long to they last? _____

Can he/she self-calm? ☐ Yes ☐ No

Does your child do what he/she is told? ☐ Yes ☐ No

Does he/she accept responsibility for his misbehaviors? ☐ Yes ☐ No

What is his/her response when being disciplined? _____

Do misbehaviors continue despite discipline? ☐ Yes ☐ No

In which situations does he/she struggle? ☐ stores ☐ restaurants ☐ riding in the car ☐ riding the bus ☐ organized activities (e.g., scouts) ☐ classroom ☐ playground ☐ other: _____

Is he/she more disruptive, defiant, or argumentative toward specific people or everyone, elaborate: _____

_____

Mood ☐ *No concerns*

Which of the following are present: ☐ irritability ☐ easily angered ☐ sadness ☐ frequently grumpy ☐ ease of frustration ☐ highs & lows ☐ upsets over minor/trivial events ☐ is withdrawn ☐ frequently complains ☐ other _____

Anxiety ☐ *No concerns*

Which of the following are present: ☐ excessive fears ☐ excessive worry ☐ jumps to worse-case scenarios ☐ overly concerned with improbable events (e.g., being kidnapped, tornados) ☐ easily overwhelmed ☐ is tense ☐ often keyed-up ☐ fixations ☐ obsessions ☐ rigid ☐ can't let things go ☐ repetitive & excessive questioning ☐ bossy/controlling ☐ nosey/in other's business ☐ is bothered when others break the rules or misbehave ☐ bothered when others touch or move belongings ☐ bothered when things are out of place ☐ often lines things up ☐ overly concerned with fairness ☐ apprehensive about new situations ☐ hesitant to try new things ☐ problems separating from parents ☐ other _____

Social ☐ *No concerns*
How many friends does your child have? _____

Which of the following are present: ☐ making friends ☐ keeping friends ☐ excessively bossy with peers ☐ aggressive with peers ☐ has problems sharing ☐ struggles taking turns ☐ problems working in groups/teams ☐ difficulty with sportsmanship ☐ overly-friendly ☐ approaches strangers ☐ invades personal space ☐ difficulty reading social cues ☐ excluded by peers ☐ frequently teased/bullied ☐ immaturity ☐ very shy ☐ other _____

Autism Spectrum ☐ *No concerns*
Does your child struggle with the following: ☐ eye contact ☐ parallel play ☐ lacks interest in others ☐ severe language delays/impairments ☐ poor social communication ☐ strict adherence to rules ☐ can't cope with change ☐ repetitive behaviors (e.g., hand-flapping, spinning), specify:_____ ☐ narrow interests, specify:_____ ☐ atypical/unusual behaviors, specify:_____ ☐ sensory challenges

During this evaluation, are we evaluating your child for an autism spectrum disorder? ☐ Yes ☐ No

Life Skills/Community/Home ☐ *No concerns*
Which of the following hygiene problems are present? ☐ Bathing/showering ☐ brushing teeth ☐ cleaning him/herself after using the restroom ☐ dressing ☐ managing menses ☐ shaving

*Does your child follow-through with household responsibilities/chores? ☐ Yes ☐ No

**Can* he/she get ready for the day in a timely manner? ☐ Yes ☐ No

**Can* he/she pick up his/her belongings? ☐ Yes ☐ No

**Can* your child do for him/herself (e.g., get own drink)? ☐ Yes ☐ No

*questions specially referring to actual *ability* not *willingness/defiance*

Does he/she know: ☐ address ☐ phone number ☐ parents/caregiver's name ☐ None

Does your child engage in risky behaviors such as: ☐ wandering/bolting from parents ☐ climbs too high ☐ jump from high places ☐ runs too fast ☐ willing to go with strangers ☐ problems crossing the street ☐ does not pay attention in or near traffic ☐ other: _____

Any problems in the home (e.g., pending divorce, custody issues, parental fighting, excessive sibling-rivalry, chaotic scheduling, neglect, etc.)? _____
_____

Overall
How long has your child experienced or demonstrated ANY of the above problems? _____

At Risk ☐ *No concerns*
Does your child makes threats of: ☐ harming others ☐ hurting him/herself ☐ suicide
If *Yes*, do these statements occur outside the *heat-of-the-moment* (e.g., if ONLY during an angry or emotional outburst, then check NO)? ☐ Yes ☐ No

Does your child have: ☐ visual hallucinations ☐ auditory hallucinations ☐ difficulty distinguishing reality from fantasy

Does (or has) your child: ☐ drink alcohol ☐ smoke tobacco ☐ use illegal substances specify (e.g., cocaine, marijuana): _____

If *Yes*, how often and for how long _____

Are there any legal issues with the **child** (e.g., probation, jump court, etc.)? ☐ Yes ☐ No
If *Yes*, please specify: _____

Support

What type of community resources and supports are available to the child and family? _____
_____

Has any family members (other than child) been involved in therapy or treatment? ☐ Yes ☐ No
If *Yes*, for what? _____

What, if any, spiritual and/or cultural factors would impact assessment or treatment _____
_____

Housing

Do you live in a ☐ house ☐ mobile home ☐ apartment
Do you ☐ rent ☐ own ☐ receive state housing assistance

Financial

Primary Source of income and employment of all wage earners in household:_____
_____

Other financial sources: ☐ child support ☐ food stamps ☐ WIC ☐ welfare ☐ social security
☐ other: _____

Family History

Is the child: ☐ Adopted
☐ In foster care?

If *Yes*, please complete the foster/adoption history at the end of this form.
Exclude adopted by marriage.

Are the child's **biological** (or adoptive) parents: ☐ Married ☐ Separated ☐ Divorced
☐ Widowed ☐ Never Married

Who has physical custody of the child? _____
Who has legal custody of the child? _____
How often does other parent see the child? _____
Is the mother/father or both re-married? ☐ Yes ☐ No
If *Yes*, Specify: _____

Has your child ever been abused? ☐ Yes ☐ No
If *Yes*, what type of abuse?☐ Physical ☐ Sexual ☐ Both
At what age was child during the abuse? _____
Who was the abuser? _____
How long did the abuse last? _____

Are there any legal issues with the child's **parents** (e.g., probation, convictions, etc.)? ☐ Yes ☐ No
If *Yes*, please specify: _____

List **ALL** people with whom the child currently lives with:

Please Note: (if part-time with other parent specify separate household and people)

Name of Person in House	Age	Gender	Relationship to Child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If any siblings are living outside the home list their names and ages:

Name	Bro/Sis	Age	Lives with
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____

Adoptive / Foster History

What age was the child first removed from biological parents? _____

Why was the child removed? _____

Who has current legal custody of the child? _____

Is the child adopted? ☐ Yes ☐ No

Age when child was first in permanent home? _____ Date of Legal Adoption: _____

If the child was adopted, does he or she KNOW they were adopted? ☐ Yes ☐ No

Does the child have any contact with biological parents? ☐ Yes ☐ No

If *Yes*, with whom: _____

How Often: _____

How has the child adjusted to foster care / adoption? _____

_____

_____

_____