Parent History Form Instructions:

1. Download Parent History Form Fill.pdf to your computer
2. Open with Adobe Reader
    a. *Mac OS users must use Adobe Reader and not Preview. If Preview is used the data will not show up when it is emailed back.*
3. Fill out the form
4. Before exiting save the file
    a. File > Save As
    b. Save the file in a place you can easily find it. Your Desktop for example
    c. Under "File Name" rename the file
        i. i.e. "Mary Brown History Form"
5. Close and reopen the file to make sure the data is saved properly.
6. Attach file to an email and send it to alison@alisonwimmer.com

Developmental & Behavioral Consultants

Client History Form

Alison Wimmer
801.458.3036
alison@alisonwimmer.com

Today's Date _____ Form is completed by ☐ Parent ☐ Guardian (please check one)

Who am I to thank for this referral? _____

Evaluation Preference? ☐ Full Day ☐ Half Day ☐ Skype ☐ Focused

Client's Name_____ Date of Birth _____

Address_____ Phone Home _____

City_____ State _____ Zip_____ Phone Cell _____

Country_____ Email _____

Mailing Address (if different from above) _____

Client lives with ☐ Parent ☐ Guardian ☐ Other _____

Mother's Name_____ Date of Birth _____

Address_____ Phone Home _____

City_____ State _____ Zip_____ Phone Cell _____

Education Completed _____ Occupation _____

Father's Name_____ Date of Birth _____

Address_____ Phone Home _____

City_____ State _____ Zip_____ Phone Cell _____

Education Completed _____ Occupation _____

Guardian's Name_____ Date of Birth _____

Address_____ Phone Home _____

City_____ State _____ Zip_____ Phone Cell _____

Education Completed _____ Occupation _____

1. CHILD INFORMATION

Siblings

Name _____ **Age** _____ **Name** _____ **Age** _____

Name _____ **Age** _____ **Name** _____ **Age** _____

Name _____ **Age** _____ **Name** _____ **Age** _____

2. MEDICAL HISTORY

Family Physician _____ **Phone Number** _____

Address _____

Client's birth weight _____ **lbs.** _____ **oz.** **Length of pregnancy** _____

Complications during pregnancy and/or delivery? ☐ **Yes** ☐ **No** **If yes, please describe** _____

_____

_____

Has the client ever had a head brain injury? ☐ **Yes** ☐ **No** **If yes, please describe** _____

_____

_____ **Date(s)** _____

Pertinent medical, neurological, visual, hearing, therapeutic, psychological, or educational testing:

Date	Examined by	Diagnosis	Recommendations
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Surgeries? ☐ **Yes** ☐ **No** **Please Describe** _____

_____

Seizures? ☐ **Yes** ☐ **No** **Frequency of Seizures** _____ **Length** _____

Type(s) _____

Currently taking seizure medications? ☐ Yes ☐ No List medication(s) _____

Seizure medications taken previously? ☐ Yes ☐ No List medication(s) _____

Currently taking other medications? ☐ Yes ☐ No List medication(s) _____

_____

Are there any medical problems which place limitations on physical activity, etc.? ☐ Yes ☐ No

List _____

_____

Broken limbs? ☐ Yes ☐ No List specifics _____

3. Health

Was the client nursed? ☐ Yes ☐ No If yes, until what age? _____

Describe the client's diet _____

_____

List dietary supplements and vitamins

_____

_____

_____

_____

_____

_____

_____

_____

Food allergies? ☐ Yes ☐ No ☐ Never Tested

_____

_____

_____

_____

	Excessive	Daily	Weekly	Rarely	Never
Vegetables					
Fruit					
Meat					
Sugar					
Artificial Sweeteners					
Artificial Coloring					
Dairy Products					
White Flour					
Tobacco					
Alcohol					

Food Cravings? ☐ Yes ☐ No

Picky eater? ☐ Yes ☐ No

Overeats? ☐ Yes ☐ No

Poor appetite? ☐ Yes ☐ No

Allergies? ☐ Yes ☐ No If yes, please describe _____

_____

Does the client have a history of cold or sinus congestion? ☐ Yes ☐ No

Does the client have a history of ear infections? ☐ Yes ☐ No

If yes, which ears have been affected? ☐ Left ☐ Right ☐ Both

How many? _____ Over what period of time? _____

Does the client have Tinnitus (ringing in the ear)? ☐ Yes ☐ No

If yes, which ears have been affected? ☐ Left ☐ Right ☐ Both

Is the Tinnitus ☐ Continuous ☐ Intermittent

Does the client have hearing loss? ☐ Yes ☐ No

If yes, which ears have been affected? ☐ Left ☐ Right ☐ Both

Degree of hearing loss _____

Does the client have hypersensitive hearing? ☐ Yes ☐ No

If yes, was it treated with sound therapy? ☐ Yes ☐ No

If yes, what was implemented? _____

Has the client had a tympanogram, audiogram, ABR? ☐ Yes ☐ No

If yes, what were the results? _____

Has the client had an eye examination? ☐ Yes ☐ No

Does the client wear glasses or contact lenses? ☐ Yes ☐ No

If yes, what is the prescription? _____

Has the client been diagnosed with any of the following: (please check)

☐ Near Sighted	☐ Far Sighted	☐ Astigmatism	☐ Amblyopia
☐ Strabismus	☐ Macular Problems	☐ Glaucoma	☐ Cataracts
☐ Nystagmus	☐ Blind	☐ Cortical Blindness	☐ Other_____

Sleep times: From _____ To _____ Naps: From _____ To _____

Client physical activity level

Daily? ☐ **Yes** ☐ **No** **How many days per week** _____

Types of activities _____

Duration of activities _____

Please check services currently being utilized:

☐ Neurologist	☐ Chiropractor	☐ Music Therapist
☐ Psychiatrist	☐ Tutor	☐ AIT, Sound Therapist
☐ Psychologist	☐ Occupational Therapist	☐ Counselor
☐ Orthopedist	☐ Physical Therapist	☐ Cardiologist
☐ Speech Therapist	☐ Osteopathic Physician	☐ EEG Neurofeedback Therapy
☐ Naturopathic Physician	☐ Vision Therapist	

☐ **Other** _____

If being seen on a weekly basis, how many times/sessions a week? _____

Other health problems? ☐ **Yes** ☐ **No** **List** _____

_____

4. BEHAVIOR

Does the client have a history of emotional or behavioral disorders? ☐ **Yes** ☐ **No**

Please describe _____

Is there a family history of emotional or behavioral disorders? ☐ **Yes** ☐ **No**

Please describe _____

Client's specific positive behaviors _____

Client's specific negative behaviors _____

Do you have specific behavioral goals for the client? ☐ **Yes** ☐ **No**

Please describe _____

_____

	Yes	No	Not Sure		Yes	No	Not Sure
Distractible				Difficulty Following Directions			
Short Attention Span				Difficulty with Parents			
Hyperactive				Difficulty with Siblings			
Hypoactive (low activity level)				Difficulty with Teachers			

	Yes	No	Not Sure		Yes	No	Not Sure
Rigid or Inflexible				Difficulty with peers			
Impulsive				Overly sensitive to sound			
Temper Tantrums				Overly sensitive to touch			
Sucks Thumb				Overly sensitive to odors			
Few or no friends				Tics			
Socially Immature				Phobias			
Perseverates (talking on topic)				Emotional			
Low Frustration Level				Overly sensitive			
Overreacts				High tolerance for pain			
Destructive Behavior				Low tolerance for pain			
Aggressive Behavior				Compliant			
Cyclical Behavior (good days/bad days)				Cooperative			
Academic Output (good days/bad days)				Obedient			
Achievement (high in some cases, low in others)				Organized			
Disorganized				Flexible			
Likes Competitive Games				Social			
Avoidance Behavior							

5. PHYSICAL MOTOR SKILLS (please check problem areas)

☐ Low Muscle Tone ☐ Creeping (on hands and knees ☐ Ataxic

☐ High Muscle Tone ☐ Walking ☐ Weak

☐ Coordination ☐ Running ☐ Balance

☐ Crawling (on stomach) ☐ Athetoid Movement ☐ Other _____

6. HAND PREFERENCE

	Right	Mixed	Left		Right	Mixed	Left
Writing				Brushing Teeth			
Eating				Combing Hair			
Throwing				Other:			

7. LANGUAGE AND READING SKILLS

	Yes	No	Not Sure		Yes	No	Not Sure
Articulation Problems				Mirror Writing			
Stammer or Stutter				Forgetful			
Aphasia				Right/Left Confusion			
Poor Pencil Grip				Poor Judge of Time			
Sloppy Writing				Poorly Organized			
Poor Reading Ability				Letter Reversals			
Difficulty Copying from a Blackboard							

8. MATH (Please check areas of concern)

	Yes	No	Not Sure		Yes	No	Not Sure
Computation				Poor Logic			
Concepts				Math Facts			
Word Problems							

9. COGNITIVE (Please check areas of concern)

	Yes	No	Not Sure		Yes	No	Not Sure
Visualization				Conceptualization			
Long-Term Memory				Short-Term Memory			

10. DEVEL0PMENTAL HISTORY

Age…

…crawled (on stomach)	**Years/Months** _____	**…used couplets** (2 words together)	**Years/Months** _____
…creep (on hands and knees)	**Years/Months** _____	**…3-4 word phrases**	**Years/Months** _____
…walked	**Years/Months** _____	**…sentences**	**Years/Months** _____
…toilet trained	**Years/Months** _____	**…conversational language**	**Years/Months** _____
…first word	**Years/Months** _____	**…read**	**Years/Months** _____

Does the client enjoy watching television? ☐ **Yes** ☐ **No** **Fine motor problems?** ☐ **Yes** ☐ **No**

Does the client enjoy reading books? ☐ **Yes** ☐ **No** **Gross motor problems?** ☐ **Yes** ☐ **No**

Speech and language problems? ☐ **Yes** ☐ **No**

11. EDUCATIONAL HISTORY

Present educational placement:

Days per week _____ **Hours of attendance** _____

☐ **Private** ☐ **Charter** ☐ **Special (please indicate classification)**

☐ **Behavioral** ☐ **Public** **Other** _____

List all school programs attending, years attended, and grade(s) completed.

_____

_____

List any educational problems (past or current)

_____

_____

List any labels, classifications, or educational diagnoses (past or current)

_____

_____

List any exceptional abilities including academic, physical, artistic, musical, etc.

_____

_____

List any classes/lessons the client is enrolled in (Musical, Physical/Sports, Art, Languages, etc.)

_____

_____

_____

Are there any events which may be currently affecting the client adversely? ☐ **Yes** ☐ **No**

Please describe _____

12. GOALS AND PLANS

What are your goals and expectations?

_____

_____

_____

_____

_____

Who will implement the program? _____

Daily length of time parents can work with client? _____

Daily length of time others can work with client? _____

I look forward to working with you and your family!