Sunny Hills Behavioral Health

CLIENT HISTORY FORM

Please be as accurate as possible as this form is an essential part of documenting your evaluation.

Who Filled This Form? _____ Relationship _____ Date _____

CLIENT INFORMATION

Name: _____ Age _____ Birthdate _____ Sex _____

School: _____ City _____ Grade/Year: _____

Ethnicity/Race: _____ Religion _____

Home Language: _____ First Language _____ Age Learned 2nd Language _____

PRESENTING SITUATION:

What are your current CONCERNS? _____

What are your STRENGTHS?

Do you have a pending exam? ☐ No ☐ Yes Type: _____ Date _____

FAMILY HISTORY

Parent 1 Name: _____ Age _____ Highest Education _____ Occupation _____

Parent 2 Name: _____ Age _____ Highest Education _____ Occupation _____

Any Family History of Significant Health/Mental Health/Developmental Problems ☐ No ☐ Yes

PREGNANCY/HEALTH AND EARLY DEVELOPMENT

Length of Pregnancy _____ weeks

Were there Illnesses/complications during pregnancy? ☐ No ☐ Yes (Explain) _____

Labor and Delivery:

Was Birth Typical? ☐ No ☐ Yes (if no, explain): _____

Birth weight _____ lbs _____ oz Length _____ in. APGAR SCORES _____

Health problems? ☐ Colic ☐ Reflux ☐ Infections ☐ Failure to Thrive ☐ Jaundice ☐ Apnea ☐ _____

INFANCY AND EARLY CHILDHOOD DEVELOPMENT

DEVELOPMENTAL MILESTONES

***********Incorrect information can impact an accurate diagnosis**********

Motor skills (walking, standing) Early On Time Late

Language Skills Early On Time Late

Social Skills Early On Time Late

Self Help Skills Early On Time Late

Early Intervention? ☐ None ☐ OT ☐ PT ☐ Speech Therapy ☐ Infant Stimulation

☐ Right Handed ☐ Left Handed ☐ No Dominance

HEALTH

Overall Health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Critical ☐ Other _____

Any recurrent/chronic/serious health Problems? ☐ No ☐ Yes List: _____

Vision is: ☐ Normal Wears Lenses ☐ No ☐ Distance ☐ Near? Other _____

Hearing is: ☐ Normal ☐ Other Aides? ☐ No ☐ Yes Explain: _____

Allergies: ☐ None ☐ Environmental (List) _____ ☐ Food (List) _____

Have you had any of the following DIAGNOSES:

☐ *NONE*

☐ Learning Disorder (specify) _____ Date diagnosed _____ By Whom? _____

☐ Attention Disorder _____ Date diagnosed _____ By Whom? _____

☐ Mental Health (specify) _____ Date diagnosed _____ By Whom? _____

☐ CBI/Concussion (specify) _____ Date diagnosed _____ By Whom? _____

☐ Autism Related (specify) _____ Date diagnosed _____ By Whom? _____

☐ Genetic Disorder (specify) _____ Date diagnosed _____ By Whom? _____

☐ Motor Disorder (specify) _____ Date diagnosed _____ By Whom? _____

☐ Other (specify) _____ Date diagnosed _____ By Whom? _____

CURRENT TREATING PROVIDERS

Physician: _____ Address _____ Phone _____

Specialist Name: _____ Treating For: _____ Dates _____

Specialty: _____ Address _____ Phone _____

Current Medications/Supplements

Medication/Supplement Start Date Dosage Frequency

EARLY INTERVENTION/SCHOOL HISTORY

Regional Center Client? ❑ Yes ❑ No Eligibility:

Current Services: Specify

Prior Services (ages):

Current Private Services? (Tutoring, OT, speech language, ABA, Floor Time, Educational Therapy, PT)

Specify:

SCHOOLS ATTENDED:

Grades or Dates *Name of School* *City*

History of Attendance Problems? ❑ No ❑ Yes Explain

Ever RETAINED? ❑ No ❑ Yes Grade Ever ADVANCED a grade? ❑ No ❑ Yes Grade

Ever SUSPENDED? ❑ No ❑ Yes Date Ever EXPELLED? ❑ No ❑ Yes Date:

SCHOOL/SPECIAL EDUCATION/504 SERVICES

Current 504 Plan? ❑ No ❑ Yes GATE? ❑ No ❑ Yes IEP? ❑ No ❑ Yes

Eligibility: Was formal assessment done? ❑ No ❑ Yes Last Eval Date:

Initial Plan Date *Current* Plan Date:

Current Goal/Accommodation Areas:

Test Accommodations at School? ❑ No ❑ Yes

❑ Extended Time
❑ Enlarged Print
❑ Frequent Breaks
❑ Mark on booklet
❑ Scribe/Word Processor
❑ Smaller setting
❑ AT/Speech to Text
❑ Reader
❑

Current Class Placement

☐General Education ☐Home Schooling ☐Private ☐Gen Ed with RSP/SAI/LC (hours/day____)

Current GPA (e.g., As, Bs, etc.)_____ Coursework: ☐ Core/CP ☐ Honors ☐ AP

Previous Exams Taken: ☐ SAT ☐ PSAT ☐ ACT ☐ ICEE Other _____

Any services provided at school: ☐ Counseling ☐ Ed Therapy ☐ Other _____

CURRENT DAILY FUNCTIONING:

Sleep: hrs./night _____ Normal bedtime:_____ Wake time_____ Trouble Waking? ☐ Yes ☐ No

Homework: Hours per night on school nights _____ Hours of electronics per day: _____

COMMUNITY INVOLVEMENT/ENRICHMENT

Involved in the following?	# of Years? Times per Week
☐ Team Sports (specify) _____	
☐ Individual Sports (specify) _____	
☐ Music/Art/Dance/Theatre	
☐ Volunteer/Community Service	
☐ Scouting or related	

CURRENT AREAS OF CONCERN (mark all that apply):

☐Attention Span
☐Distractibility
☐Organization
☐Executive Functions
☐Homework
☐Independence
☐Chores
☐Self-Care/Hygiene
☐Social skills
☐Aggression
☐Frustration
☐Depression
☐Anxiety
☐Tics
☐Sleep Problems
☐Repetitive behaviors
☐Word Reading/ Phonics
☐Reading Comprehension
☐Reading Fluency
☐Math Calculation
☐Applied Math
☐Spelling
☐Writing
☐Handwriting
☐Auditory Processing
☐Visual Processing
☐Fine Motor Skills
☐Gross Motor Skills
☐Listening
☐Speaking
☐Other: _____

How old were you when the current problems first surfaced? _____