Elements of a Child Abuse History

The default option is a comprehensive assessment. Truncating the data base may be necessary, such as when no adult informant is available, or permissible, such as when a birth history has no relevance to sexual abuse injuries. If the full extent of injuries has not be completely assessed, such as when skeletal surveys and intracranial imaging is pending, it is hard to know what information is necessary.

A. History of Present Concern

1. Child's history
   taken separately from adults in a forensically sensitive manner
2. Adult informant's history

taken from each observer separately
how was abuse concern arrived at
what was actually seen
what other data was gathered and how

B. Past Medical History

1. Birth history (gestation, delivery type, Apgars, complications)
2. Hospitalizations
3. Surgery
4. Chronic and recurrent illnesses
5. Significant physical traumas
6. Chronic and current medications
   (prescription, non-prescription, herbals, nutritionals)
7. Medication and latex allergies
8. Recent and current acute illnesses
9. Dietary history
10. Review of systems

C. **Behavioral and Developmental History**

1. Developmental milestones
2. Temperament of child
2. Current developmental abilities
3. Toilet training history
4. Sleep history
5. School performance
6. Behavioral concerns
7. Behavior changes
8. Sexual behavior
9. From child, screening questions for depression, anxiety, suicidality PTSD
10. From child, history of risk taking (sex, drugs, alcohol)

D. Social History

1. Residents of all occupied households

2. Exposure to domestic violence
3. Exposure to adult sexuality
4. Parenting and disciplinary practices
5. Abuse history of involved adults

E. Family Medical History (as appropriate)

1. Coagulopathy
2. Osteogenesis imperfecta
3. Sexually transmitted infections
4. Others as appropriate