Pediatric Neuropsychology History Questionnaire

"Commitment to Children, their Health, Development and Learning"
Evaluation and Brain Building Programs that Develop Potential and Success at Home, School and Beyond

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Date_____

GENERAL INFORMATION

Child's Name:_____

Address: _____

_____

Home Phone:_____

Age:_____ Birth Date:_____

Adopted: Yes or No

Adoption Country:_____

Age at Adoption:_____

Health at Adoption, Explain: _____

_____

_____

Are you aware of any birth family health history?: _____

_____

Place of Adoption (Hospital, Orphanage, Foster Home, other):_____

_____

_____

Additional Information regarding Adoption: _____

_____

_____

Mother's Name: _____ Age: _____

Occupation: _____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Best Phone to be reached at:_____

Email: _____

Education (Highest Grade Completed):_____

Academic Difficulties (describe):_____

_____

_____

Physical/Mental Health Problems (Child-Teen-Adult), Describe: _____

_____

_____

Father's Name:_____ Age: _____

Occupation: _____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Best Phone to be reached at:_____

Email: _____

Education (Highest Grade Completed):_____

Academic Difficulties (describe):_____

_____

_____

Physical/Mental Health Problems (Child-Teen-Adult), Describe: _____

_____

_____

Step-Father Name: _____ Age:_____

Occupation: _____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Best Phone to be reached at:_____

Email: _____

Education (Highest Grade Completed):_____

Academic Difficulties (describe):_____

_____

Physical/Mental Health Problems (Child-Teen-Adult), Describe: _____

_____

_____

Step-Mother Name: _____ Age:_____

Occupation: _____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Best Phone to be reached at:_____

Email: _____

Education (Highest Grade Completed):_____

Academic Difficulties (describe):_____

_____

_____

Physical/Mental Health Problems (Child-Teen-Adult), Describe: _____

_____

_____

Are the child's parent's living together?_____

Describe:_____

If no, how old was the child when the parents were separated?: _____

If no, how old was the child when the parents were divorced?: _____

Sibling Information

Name	Age	Academic/ Medical Problems

Other persons living in the house

Name	Age	Relationship

Biological Extended Family Health History (i.e. Grandparents, aunts/uncles, cousins), describe: _____

_____

_____

_____

_____

REFERRAL INFORMATION

Person who referred you for testing: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Reason for referral: _____

_____

_____

Child's Primary Care Physician: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Does your child see any other Physicians, Allied Health Specialists, or Therapists?

Name	Phone	Service	Length of Relationship

Is your child taking any medication?

Medication/Dose	Reason	Frequency

Is your child taking any vitamins/nutrition supplements?

Name	Reason	Frequency

Does your child have any allergies, food sensitivities, or airborne sensitivities, explain: _____

_____

_____

_____

_____

_____

Has there been any recent loss, stress, or trauma affecting your child's or family life?: _____

_____

_____

_____

ACADEMIC HISTORY

Did your child receive any early intervention services (0-3 years)? Explain (i.e. OT, PT, Speech/Language, Developmental Therapy, etc): _____

_____

_____

_____

_____

Did your child receive any intervention services (Early Childhood→ College)? Explain and specify grade level (i.e. OT, PT, Speech/Language, Counseling): _____

_____

_____

_____

_____

What school does your child attend?: _____

Address: _____

Grade: _____

Describe your child's overall academic performance:

Gifted *Above Average* *Average* *Below Average*

Explain: _____

_____

_____

Describe classroom behavior: _____

_____

Has your child had any of the following:

_____ Tutoring, explain: _____

_____ Counseling, explain: _____

_____ Special Classes, explain: _____

_____ Therapeutic School, explain: _____

_____ Case Study, date/results: _____

_____

_____ Classroom Accommodations (504 Plan), explain: _____

_____

_____ IEP (Individual Education Plan), explain: _____

_____

_____ Gifted Program, explain: _____

Has your child ever failed or repeated any grades, explain: _____

_____

_____

_____ _____

Have you ever been told that your child has a learning disability? _____

_____

_____ _____

_____

_____ _____

Have you ever been told that your child was hyperactive/hypoactive or had ADD/ADHD? _____

_____

_____

_____

_____

Does your child read for pleasure? *Yes* *No*

If your child has had special services, answer the following:

Services provided (name/frequency)?

_____

_____

_____

_____

_____

_____

_____

Assistive Technology, explain:

_____

_____

_____

_____

_____

_____

DEVELOPMENTAL HEALTH AND SOCIAL HISTORY

Birth Mother/Father at time of conception, explain any illness: _____

_____

_____

Did the child's mother take any medication during pregnancy? ___ Yes ___ No

If yes, list: _____

Did the child's mother smoke during pregnancy? ___ Yes ____ No

If yes, how many cigarettes per day? _____

Did the child's mother drink alcohol during pregnancy? ___ Yes ____ No

If yes, list kind and amount per day: _____

Did the child's mother use drugs during pregnancy? ____ Yes ___ No

If yes, list drugs and amounts: _____

Did the child's mother experience any heightened stress during pregnancy? __ Yes __ No

If yes, please explain: _____

Were there any problems during pregnancy? ____ Yes ____ No

If yes, please explain: _____

Were there any problems during labor or delivery? ___ Yes ___ No

If yes, please explain: _____

Birth Weight: _____ Was the birth premature? ____ Yes ___ No

If yes, how many weeks premature?: _____

Were there any complications after delivery? ____ Yes ____ No

If yes, please explain: _____

Please put a check next to the following conditions regarding your child's history, if applicable:

_____ Surgery, Explain: _____

_____ Acquired Head Injury (Concussion-Mild -Traumatic), Explain: _____

_____ Vision Difficulties (glasses, contacts, etc), Explain: _____

_____ Hearing Difficulties (aid/devices), Explain: _____

_____ Speech/Language delay, Explain: _____

_____ Chronic Ear Infections, Explain: _____

_____ Chronic Strep Infections, Explain:_____

_____ Chronic Constipation/Diarrhea, Explain: _____

_____ Respiratory Difficulty, Explain: _____

_____ Difficulty Breathing, Explain: _____

_____ Snoring, Explain: _____

_____ Headaches, Explain: _____

_____ Stomach Aches, Explain: _____

_____ Unusual Birthmarks, Explain: _____

_____ Alcohol/Drug Misuse/Abuse, Explain: _____

_____ Legal Difficulties, Explain: _____

_____ Other, Explain: _____

Please explain the following early age behaviors, as applicable:

_____ Excessive Saliva/Drooling, Explain: _____

_____ Difficulty Rolling side-to-side, Explain: _____

_____ Sensory Seeking Behaviors, Explain: _____

_____ Sensory Sensitive Behaviors, Explain: _____

Identify when the following behaviors first occurred:

	Age
Babble/Coo	
Expressed Short Phrases	
Spoke Full Sentences	
Crawl (regular/army)	
Walked (without holding on)	
Toilet /Trained: Bladder	
Toilet Trained: Bowel	

BEHAVIORAL, SOCIAL, and EMOTIONAL HISTORY

Please describe strengths and difficulties of your child: _____

_____

_____

_____

_____

What brings the most calm/peace to your child? : _____

_____

_____

_____

_____

Describe your family communication: _____

_____

_____

_____

_____

Describe Marital/Sibling relationships and communication: _____

_____

_____

_____

_____

Please place a check mark next to any conditions that describe behaviors, emotions, or social interaction you have noted regarding your child:

_____ Delay learning to read/write/color, Explain: _____

_____ Behavioral problems at home, Explain: _____

_____

_____

_____ Behavioral problems at school, Explain: _____

_____

_____

_____

_____

_____ Bedwetting after age 4: _____

_____ Difficulty falling asleep/staying asleep: _____

_____ Excessive nightmares: _____

_____ Difficulty paying attention: _____

_____ Hyper/Hypo- active: _____

_____ Difficulty following directions: _____

_____ Blank or staring spells:_____

_____ Impulsivity: _____

_____ Disorganized: _____

_____ Daydreams often: _____

_____ Easily distracted: _____

_____ Trouble sitting still: _____

_____ Memory problems/forgetful: _____

_____ Depressed/withdrawn: _____

_____ Repetitive behaviors (motor, vocal): _____

_____ Repetitive ideas, routines, patterns: _____

_____ Aggressive to self, Explain: _____

_____ Aggressive to others, Explain: _____

_____ Aggressive to objects, Explain: _____

_____ Shy: _____

_____ Thoughts of hurting self or others, Explain: _____

_____ Reports of hearing imaginary voices, Explain: _____

_____ Reports of seeing and feeling imaginary things, Explain: _____

_____ Tantrums: _____

_____ Excessive worry: _____

_____ Poor self-esteem: _____

_____ Cries easily and often: _____

_____ Acts young for age: _____

_____ Frustrates easily: _____

_____ Excitable: _____

_____ Stubborn: _____

_____ Difficulty making friends: _____

SCHOOL RELATED BEHAVIORS

_____ Frequent absenteeism: _____

_____ Frequent tardiness: _____

_____ Poor handwriting: _____

_____ Academic struggles: _____

_____ Academic Probation: _____

_____ Prefers to relate to younger/older children, Explain: _____

_____ School detentions, Explain: _____

_____ School suspension(s) (in-school or out-of-school), Explain: _____

_____ School expulsion (s), Explain: _____

Additional Information: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

CURRENT MEDICAL INFORMATION

Lab and diagnostic procedures (i.e. EEG, CT, MRI):

Test: _____

Date: _____

Result: _____

_____

Test: _____

Date: _____

Result: _____

_____

Test: _____

Date: _____

Result: _____

_____

Test: _____

Date: _____

Result: _____

_____

Test: _____

Date: _____

Result: _____

At the time of your initial appointment, please bring **COPIES** of pertinent medical, educational, and allied health evaluation and treatment records. Thank you and we look forward to seeing you and your child.