



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*

Dr. Val Scaramella Nowinski
Pediatric Neuropsychology

Pediatric Neuropsychology Diagnostic and Treatment Center
Century Medical Park
16001 S. 108th Ave, Suite 2
Orland Park, IL 60467
Phone: (708) 403-9000
Fax: (708) 403-9988

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?: _____

Pediatric Neuropsychology History Questionnaire

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: _____

Pediatric Neuropsychology History Questionnaire

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): _____

Pediatric Neuropsychology History Questionnaire

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?: _____

Pediatric Neuropsychology History Questionnaire

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: _____

Pediatric Neuropsychology History Questionnaire

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

Pediatric Neuropsychology History Questionnaire

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: _____

Pediatric Neuropsychology History Questionnaire

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? _____

Pediatric Neuropsychology History Questionnaire

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: _____

Pediatric Neuropsychology History Questionnaire

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: _____

Pediatric Neuropsychology History Questionnaire

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: _____

Pediatric Neuropsychology History Questionnaire

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: _____

Pediatric Neuropsychology History Questionnaire

- _____ 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: _____

Pediatric Neuropsychology History Questionnaire

____ 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.