



Child Neuropsychological History

Please complete the following form as accurately as possible as it is an important component of your child's evaluation. Components of this questionnaire may not apply to your child, in which case it is acceptable to leave those portions blank or write N/A (not applicable). If necessary, please use additional pages to explain your child's history or presentation.

Client Information

Child's Name _____ Today's Date _____
Gender _____ Age _____ Birthdate _____
Home Address _____
Ethnic/Racial Background _____ Religion _____
Primary Language _____ Handedness (circle): Right Left Ambidextrous
Established Diagnoses _____

Respondent's Information

Name _____ Relationship to Child _____
Home Address _____
Home Phone _____ Cell Phone _____

Referral Information

Who referred your child for an evaluation? _____

From (Institute or Affiliation): _____

Briefly describe what concerns have led you to seek an evaluation _____

What questions would you like to have answered?

- 1) _____
- 2) _____
- 3) _____

What types of interventions/accommodations have been attempted to date? _____

PROBLEM CHECKLIST

Report all problems that apply by checking the **OLD** or **NEW** problem box. Rate the severity of any checked item from 0 to 5 using the scale in each section. Compare your child to children of the same age.

First, complete the following guide about how you will use each description:

The OLD description	The NEW description
<input type="checkbox"/> The problem existed before a recent illness/injury	<input type="checkbox"/> The problem began after a recent illness or injury
<input type="checkbox"/> The problem began more than 1 year ago	<input type="checkbox"/> The problem began within the last year

1. Problem Solving

**0= Not Present 1= Mild 2= Mild to Moderate 3= Moderate
4= Moderate to Severe 5= Severe**

OLD	NEW	Rate	Child has difficulty....
<input type="checkbox"/>	<input type="checkbox"/>		Learning new or complex activities or concepts
<input type="checkbox"/>	<input type="checkbox"/>		With organizing activities, schoolwork, or personal items
<input type="checkbox"/>	<input type="checkbox"/>		Solving problems in an organized and coherent fashion
<input type="checkbox"/>	<input type="checkbox"/>		Understanding explanations
<input type="checkbox"/>	<input type="checkbox"/>		Benefiting from experience (making the same error repeatedly)
<input type="checkbox"/>	<input type="checkbox"/>		Switching from one activity to another (transitions)
<input type="checkbox"/>	<input type="checkbox"/>		Varying play/recreational activities, or varying problem solving strategies (inflexibility)
<input type="checkbox"/>	<input type="checkbox"/>		Completing activities in a reasonable period of time, or understanding time constraints
<input type="checkbox"/>	<input type="checkbox"/>		Making decisions
<input type="checkbox"/>	<input type="checkbox"/>		Planning ahead
<input type="checkbox"/>	<input type="checkbox"/>		Doing things in the correct order (sequencing)
<input type="checkbox"/>	<input type="checkbox"/>		Describing the steps involved in completing an activity or solving a problem
<input type="checkbox"/>	<input type="checkbox"/>		Becoming quickly frustrated and giving up easily (frustration-tolerance)
<input type="checkbox"/>	<input type="checkbox"/>		Other:

In new situations, the child tends to learn by: talking a lot listening and observing
 touching/handling

2. Language

0= Not Present 1= Mild 2= Mild to Moderate 3= Moderate
4= Moderate to Severe 5= Severe

OLD	NEW	Rate	
<input type="checkbox"/>	<input type="checkbox"/>		Articulation: <input type="checkbox"/> omits sounds <input type="checkbox"/> substitutes sounds <input type="checkbox"/> distorts sounds <input type="checkbox"/> mixes sequences (e.g. 'aminal')
<input type="checkbox"/>	<input type="checkbox"/>		Fluency: <input type="checkbox"/> difficulty finding the right word to say <input type="checkbox"/> slow, labored speech <input type="checkbox"/> limited amount of speech
<input type="checkbox"/>	<input type="checkbox"/>		Speaks in a monotone (very little emotion or variability in speech)
<input type="checkbox"/>	<input type="checkbox"/>		Talks much more than average
<input type="checkbox"/>	<input type="checkbox"/>		Talks in an odd manner
<input type="checkbox"/>	<input type="checkbox"/>		Jumps between topics or rambles
<input type="checkbox"/>	<input type="checkbox"/>		Odd or unusual language or vocal sounds
<input type="checkbox"/>	<input type="checkbox"/>		Difficulty understanding what others are saying
<input type="checkbox"/>	<input type="checkbox"/>		Difficulty understanding what they are reading
<input type="checkbox"/>	<input type="checkbox"/>		Difficulty understanding sarcasm or metaphors
<input type="checkbox"/>	<input type="checkbox"/>		Other:

3 School Skills

Rate each skill as compared to other children the same age

Poor	Average	Strong	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reading letters or words
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reading comprehension
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Writing letters (correct form, proper orientation)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Written expression (forming ideas, organization, grammar, etc)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spelling
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Math - Difficulty with: <input type="checkbox"/> written math <input type="checkbox"/> mental calculations <input type="checkbox"/> word problems
<input type="checkbox"/>	Needs more time than other children to complete school work <i>Does your child receive extended time in school? YES NO</i>		
<input type="checkbox"/>	Difficulty with homework:		
<input type="checkbox"/>	Other school problems:		
Difficulty with school seemed to begin at age/grade:			

4. Memory & Learning			0= Not Present 1= Mild 2= Mild to Moderate 3= Moderate 4= Moderate to Severe 5= Severe
OLD	NEW	Rate	Frequently forgets....
<input type="checkbox"/>	<input type="checkbox"/>		Where they leave toys, schoolwork, or other objects
<input type="checkbox"/>	<input type="checkbox"/>		What happened recently (e.g. prior meal)
<input type="checkbox"/>	<input type="checkbox"/>		What happened days/weeks ago
<input type="checkbox"/>	<input type="checkbox"/>		School assignments
<input type="checkbox"/>	<input type="checkbox"/>		What they have been told recently
<input type="checkbox"/>	<input type="checkbox"/>		What they are supposed to be doing
<input type="checkbox"/>	<input type="checkbox"/>		Other:
<input type="checkbox"/> Can recognize something, even if they cannot freely recall it			
Since a recent accident, child has difficulty: <input type="checkbox"/> recalling events before the accident <input type="checkbox"/> recalling new events			

5. Nonverbal Skills			0= Not Present 1= Mild 2= Mild to Moderate 3= Moderate 4= Moderate to Severe 5= Severe
OLD	NEW	Rate	
<input type="checkbox"/>	<input type="checkbox"/>		Difficulty with puzzles, Legos, blocks, or similar games
<input type="checkbox"/>	<input type="checkbox"/>		Confusion with direction (left/right) or orientation (back/front; up/down)
<input type="checkbox"/>	<input type="checkbox"/>		Problems drawing or copying
<input type="checkbox"/>	<input type="checkbox"/>		Does not reliably identify colors [<input type="checkbox"/> is color blind]
<input type="checkbox"/>	<input type="checkbox"/>		Difficulty recognizing objects or people they should know
<input type="checkbox"/>	<input type="checkbox"/>		Difficulty with dressing (e.g. tying shoes, using a zipper) that is not due to a physical disability
<input type="checkbox"/>	<input type="checkbox"/>		Seems unable to recognize nonverbal cues of others (facial or body expressions)
<input type="checkbox"/>	<input type="checkbox"/>		Gets lost easily, even on familiar routes
<input type="checkbox"/>	<input type="checkbox"/>		Other:
Child is better with: <input type="checkbox"/> language (vs. hands-on activities) <input type="checkbox"/> hands-on activities (vs. language)			

6. Motor Coordination			0= Not Present 1= Mild 2= Mild to Moderate 3= Moderate 4= Moderate to Severe 5= Severe
OLD	NEW	Rate	
			Left side Right Side
<input type="checkbox"/>	<input type="checkbox"/>		Muscle weakness or paralysis <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Muscle tightness or spasticity <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Tremor <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Drops things more often than most children <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Poor fine motor skills (e.g. trouble using a pencil, scissors) <input type="checkbox"/> <input type="checkbox"/>

<input type="checkbox"/>	<input type="checkbox"/>		Clumsy or awkward	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Walking (gait) problems	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Odd movements (posturing, peculiar hand movements, etc.)		
<input type="checkbox"/>	<input type="checkbox"/>		Involuntary or repetitive movements	<input type="checkbox"/> eye/facial	<input type="checkbox"/> vocal
				<input type="checkbox"/> limbs	<input type="checkbox"/> body
<input type="checkbox"/>	<input type="checkbox"/>		Oral (mouth) motor problems		
<input type="checkbox"/>	<input type="checkbox"/>		Problems with balance		
<input type="checkbox"/>	<input type="checkbox"/>		Other:		

7. Sensory

**0= Not Present 1= Mild 2= Mild to Moderate 3= Moderate
4= Moderate to Severe 5= Severe**

OLD	NEW	Rate		Left side	Right Side
<input type="checkbox"/>	<input type="checkbox"/>		Vision problems	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Loss of feeling on skin	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Difficulty smelling or tasting foods		
<input type="checkbox"/>	<input type="checkbox"/>		Overly sensitive to	<input type="checkbox"/> touch	<input type="checkbox"/> light
				<input type="checkbox"/> sound	
<input type="checkbox"/>	<input type="checkbox"/>		Other:		

8. Physical

**0= Not Present 1= Mild 2= Mild to Moderate 3= Moderate
4= Moderate to Severe 5= Severe**

OLD	NEW	Rate	
<input type="checkbox"/>	<input type="checkbox"/>		Frequently complains of headaches or nausea
<input type="checkbox"/>	<input type="checkbox"/>		Has dizzy spells
<input type="checkbox"/>	<input type="checkbox"/>		Excessive tiredness
<input type="checkbox"/>	<input type="checkbox"/>		Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>		Excessive thirst
<input type="checkbox"/>	<input type="checkbox"/>		Other:

9. Social

**0= Not Present 1= Mild 2= Mild to Moderate 3= Moderate
4= Moderate to Severe 5= Severe**

OLD	NEW	Rate	
<input type="checkbox"/>	<input type="checkbox"/>		Difficulty getting along with classmates
<input type="checkbox"/>	<input type="checkbox"/>		Problems making and/or keeping friends
<input type="checkbox"/>	<input type="checkbox"/>		Bullying peers
<input type="checkbox"/>	<input type="checkbox"/>		The victim of bullying
<input type="checkbox"/>	<input type="checkbox"/>		Other:

10. Behavior

**0= Not Present 1= Mild 2= Mild to Moderate 3= Moderate
4= Moderate to Severe 5= Severe**

OLD	NEW	Rate		OLD	NEW	Rate	
<input type="checkbox"/>	<input type="checkbox"/>		Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>		Low self-esteem
<input type="checkbox"/>	<input type="checkbox"/>		Daytime toilet issues	<input type="checkbox"/>	<input type="checkbox"/>		Attached to things, not people
<input type="checkbox"/>	<input type="checkbox"/>		Dependent for age	<input type="checkbox"/>	<input type="checkbox"/>		Withdrawn (solitary) play
<input type="checkbox"/>	<input type="checkbox"/>		Depressed	<input type="checkbox"/>	<input type="checkbox"/>		Difficulty falling/staying asleep
<input type="checkbox"/>	<input type="checkbox"/>		Unmotivated	<input type="checkbox"/>	<input type="checkbox"/>		Nightmares/ Sleepwalking
<input type="checkbox"/>	<input type="checkbox"/>		Anorexia/ Binge eating	<input type="checkbox"/>	<input type="checkbox"/>		Poor social skills
<input type="checkbox"/>	<input type="checkbox"/>		Emotional	<input type="checkbox"/>	<input type="checkbox"/>		Impulsive / disinhibited
<input type="checkbox"/>	<input type="checkbox"/>		Fearful or nervous	<input type="checkbox"/>	<input type="checkbox"/>		Unemotional
<input type="checkbox"/>	<input type="checkbox"/>		Immature for age	<input type="checkbox"/>	<input type="checkbox"/>		Uninterested in people
<input type="checkbox"/>	<input type="checkbox"/>		Engages in risky (dangerous) behaviors	<input type="checkbox"/>	<input type="checkbox"/>		Fears/phobias
<input type="checkbox"/>	<input type="checkbox"/>		Engages in repetitive behaviors	<input type="checkbox"/>	<input type="checkbox"/>		Other:

<input type="checkbox"/>	<input type="checkbox"/>		Engages in self-mutilating or stimulating behavior	(explain):			
<input type="checkbox"/>	<input type="checkbox"/>		Makes suicidal acts or statements	(explain):			
<input type="checkbox"/>	<input type="checkbox"/>		Has unusual/bizarre beliefs or behaviors	(explain):			
<input type="checkbox"/>	<input type="checkbox"/>		Demonstrates inappropriate sexual behaviors	(explain):			
<input type="checkbox"/> aggressive towards people or animals			<input type="checkbox"/> destructive towards items/materials	<input type="checkbox"/> ignores rules/ rebellious		<input type="checkbox"/> engages in fire-setting	
<input type="checkbox"/> steals			<input type="checkbox"/> significant anger	<input type="checkbox"/> lies excessively		<input type="checkbox"/> runs away	
<input type="checkbox"/> legal problems (explain) :							
<input type="checkbox"/> suspected or confirmed alcohol/drug use (explain):							
<input type="checkbox"/> child's behavior has recently changed (explain) :							
<input type="checkbox"/> behavior varies by setting (e.g. different at home versus school): (explain) :							

11. Attention

0= Not Present 1= Mild 2= Mild to Moderate 3= Moderate
4= Moderate to Severe 5= Severe

OLD	NEW	Rate	
<input type="checkbox"/>	<input type="checkbox"/>		Mind appears to go blank at times, or loses train of thought
<input type="checkbox"/>	<input type="checkbox"/>		Difficulty paying attention <input type="checkbox"/> in class <input type="checkbox"/> at home <input type="checkbox"/> with peers
<input type="checkbox"/>	<input type="checkbox"/>		Attention starts out OK, but cannot sustain it
<input type="checkbox"/> Attentional problems improve with some activities (e.g. better with TV or video games than when required to listen in class)			
Problems with attention seemed to start around age:			
Child seems: <input type="checkbox"/> inattentive <i>and</i> hyperactive <input type="checkbox"/> inattentive but not hyperactive			

12. Please check what, if any, of the following behaviors your child displays more than same-aged peers *and* have been present for at least the past 6 months:

Mild	Moderate	Severe	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inattentive to details or makes careless mistakes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sustaining attention over time in schoolwork or play
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does not seem to listen when spoken to
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does not follow through on instructions and fails to complete schoolwork or other activities
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty organizing activities
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoids or dislikes activities that require a lot of mental effort (e.g. schoolwork, homework)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loses things necessary for tasks at home or school
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily distracted by: <input type="checkbox"/> sights <input type="checkbox"/> sounds <input type="checkbox"/> physical sensations
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Forgetful in daily activities
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fidgety or restless when seated (e.g. taps hands or feet)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leaves seat in classroom or other situations that require them to remain seated
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runs or climbs when it is inappropriate to do so, or feels very restless
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty playing quietly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Always moving or acts as if driven by a motor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Talks excessively
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurts out answers before questions are completed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty waiting their turn in class or games
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interrupts or intrudes on others frequently
Overall, most of the noted problems developed...			<input type="checkbox"/> gradually <input type="checkbox"/> < in between > <input type="checkbox"/> quickly
Most of the noted problems occur...			<input type="checkbox"/> occasionally <input type="checkbox"/> < in between > <input type="checkbox"/> often
Compared to same-aged peers, child has...			<input type="checkbox"/> few problems <input type="checkbox"/> < in between > <input type="checkbox"/> more problems

PREGNANCY

(pregnancy information is unknown)

How often did the mother see the doctor during her pregnancy with this child?

- As scheduled by the doctor Rarely Not at all Was unaware of this pregnancy for a long time

List all **medications** the mother took (prescribed and over the counter):

1-2 months <i>before</i> this pregnancy <input type="checkbox"/> none	<i>During</i> this pregnancy <input type="checkbox"/> none

During the pregnancy, which of the following did the mother use?

	Describe pattern of use...
<input type="checkbox"/> None of the below	
<input type="checkbox"/> Alcohol	
<input type="checkbox"/> Caffeine (coffee, tea, etc.)	
<input type="checkbox"/> Recreational drugs (marijuana, cocaine, etc)	
<input type="checkbox"/> Tobacco	
<input type="checkbox"/> Other (describe)	

Check all conditions the mother experienced during her pregnancy.

	Describe any checked items
<input type="checkbox"/> None of the below	
<input type="checkbox"/> Accident	
<input type="checkbox"/> Anemia	
<input type="checkbox"/> Bleeding (severe or frequent spotting)	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> High blood pressure	
<input type="checkbox"/> Illness	
<input type="checkbox"/> Preeclampsia, Eclampsia, or Toxemia	
<input type="checkbox"/> Surgery	
<input type="checkbox"/> Vomiting (severe or frequent)	
<input type="checkbox"/> Psychological Problems or stress	
<input type="checkbox"/> Other	

The mother's **overall physical health** during pregnancy: Good Poor (*explain* _____)

The baby....	Describe
<input type="checkbox"/> had medical problems in the days following birth	
<input type="checkbox"/> was provided with special equipment	
<input type="checkbox"/> was transferred to a special unit or service	

How long did the baby stay in the hospital? _____

How many pregnancies before this child _____ How many were live births _____

DEVELOPMENT

Please indicate when your child began the following tasks. For **Early** or **Late**, write in age (if known).

	Early	Average	Late	Compared to Siblings		
Motor Skills						
Crawled	<input type="checkbox"/>	<input type="checkbox"/> 6-9 mos	<input type="checkbox"/>	<input type="checkbox"/> Early	<input type="checkbox"/> Same	<input type="checkbox"/> Late
Walked alone (2-3 steps)	<input type="checkbox"/>	<input type="checkbox"/> 9-18 mos	<input type="checkbox"/>	<input type="checkbox"/> Early	<input type="checkbox"/> Same	<input type="checkbox"/> Late
Pick up small objects with thumb and one finger	<input type="checkbox"/>	<input type="checkbox"/> 1 – 2 years	<input type="checkbox"/>	<input type="checkbox"/> Early	<input type="checkbox"/> Same	<input type="checkbox"/> Late
Hold a crayon with thumb and fingers/ make snips with scissors	<input type="checkbox"/>	<input type="checkbox"/> 2-3 years	<input type="checkbox"/>	<input type="checkbox"/> Early	<input type="checkbox"/> Same	<input type="checkbox"/> Late
Language Skills						
Followed simple commands	<input type="checkbox"/>	<input type="checkbox"/> 12-18 mos	<input type="checkbox"/>	<input type="checkbox"/> Early	<input type="checkbox"/> Same	<input type="checkbox"/> Late
Said several single	<input type="checkbox"/>	<input type="checkbox"/> 12-18 mos	<input type="checkbox"/>	<input type="checkbox"/> Early	<input type="checkbox"/> Same	<input type="checkbox"/> Late
Used simple sentences	<input type="checkbox"/>	<input type="checkbox"/> 18-30 mos	<input type="checkbox"/>	<input type="checkbox"/> Early	<input type="checkbox"/> Same	<input type="checkbox"/> Late
Self-Help Skills						
Toilet trained	<input type="checkbox"/>	<input type="checkbox"/> 2-3 yrs	<input type="checkbox"/>	<input type="checkbox"/> Early	<input type="checkbox"/> Same	<input type="checkbox"/> Late
<input type="checkbox"/> cannot toilet independently due to physical problem						
Overall Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Early	<input type="checkbox"/> Same	<input type="checkbox"/> Late

Describe any significant **developmental problems**: [there were none] _____

Describe the child's **muscle control** as an infant in each of the four areas:

Neck and Head <input type="checkbox"/> OK <input type="checkbox"/> Tight <input type="checkbox"/> Weak or loose	Legs <input type="checkbox"/> OK <input type="checkbox"/> Tight <input type="checkbox"/> Weak or loose
Arms <input type="checkbox"/> OK <input type="checkbox"/> Tight <input type="checkbox"/> Weak or loose	Trunk <input type="checkbox"/> OK <input type="checkbox"/> Tight <input type="checkbox"/> Weak or loose

As a baby, the child: had GE reflux was diagnosed as Failure-to- Thrive was fed through a tube

The baby's appetite was: good, ate well poor

The baby's growth was: good, grew nicely poor, failed to gain weight as expected

Describe the child's **early temperament** (up to approximately age 5):

		in-between	
Physical activity level	low activity level <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> high activity level
Sleeping & eating schedule	regular & predictable <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> irregular and unpredictable
Unfamiliar situations	Inhibited, cautious <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> disinhibited, spontaneous
Concentration	concentrated well <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> very distractible
Social	very shy, timid <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> very friendly
Persistence with activities	stayed with activities <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> gave up quickly
Sensitivity to environment	sensitive/ easily aroused <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> not sensitive
Intensity	calm, even tempered <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> overreacted, emotional
Mood	happy <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> irritable or unhappy

MEDICAL & HEALTH HISTORY

Pediatrician: _____ **Phone:** _____

When was your child's last check-up _____

Findings _____

Overall, the child has been sick: Not much at all An average amount Much of the time

Currently, they complain of: Headaches Stomachaches Nausea Vague Symptoms

Check all of the following that have applied to your child:

<input type="checkbox"/> AIDS, ARC, or HIV+	<input type="checkbox"/> Cancer	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Metabolic disorder
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Kidney disorder	<input type="checkbox"/> Mumps
<input type="checkbox"/> Anemia	<input type="checkbox"/> Colds (excessive)	<input type="checkbox"/> Learning disability	<input type="checkbox"/> Oxygen deprivation
<input type="checkbox"/> Apnea	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Liver disorder	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Blood disorder	<input type="checkbox"/> Enzyme deficiency	<input type="checkbox"/> Lung disorder	<input type="checkbox"/> Spina bifida
<input type="checkbox"/> BPD	<input type="checkbox"/> Genetic disorder	<input type="checkbox"/> Measles	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Brain disorder	<input type="checkbox"/> Heart disorder/defect	<input type="checkbox"/> Immune system disorder	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Broken bones
<input type="checkbox"/> Other:			

The child has a **history of being abused or neglected**, or has witnessed **domestic violence**. Explain.

Has DCF (or similar services) been involved? Explain. _____

Medication History Please list all medications your child is currently prescribed, along with any medications that have been tried in the past. (Additional page available at end of form, if needed).

Medication	Dosage/ Frequency	To Treat...	Dates	Side-Effects/ Degree of Benefit

Have they had a very bad reaction or negative side-effect to a medication? Explain. _____

Has your child swallowed a poison or drug accidentally? Describe age and circumstance. _____

What is the child's current **height:** _____ **weight:** _____

Child: wears glasses [farsighted nearsighted other: _____]
 uses hearing aid [right ear left ear]
 uses other aids _____

The child has had approximately _____ **ear infections** from ages _____ to _____
Treatments provided: antibiotics drainage tubes [age _____] Other _____

The child has a physical abnormality or unusual physical trait _____

Seizures: The child has *not* suffered a seizure The child has epilepsy or has had a seizure, if checked please complete below.

<i>Partial:</i>	<input type="checkbox"/> Simple <input type="checkbox"/> Complex (with unconsciousness) <input type="checkbox"/> Partial evolving into generalized
<i>Generalized:</i>	<input type="checkbox"/> Absence (Petit mal) <input type="checkbox"/> Myoclonic <input type="checkbox"/> Clonic <input type="checkbox"/> Tonic <input type="checkbox"/> Tonic-Clonic (Grand mal) <input type="checkbox"/> Atonic
<i>Other:</i>	<input type="checkbox"/> Unclassified type <input type="checkbox"/> Febrile (fever) seizure <input type="checkbox"/> 30 minute seizure <input type="checkbox"/> Seizure from unknown cause
Describe any physical/behavioral symptoms:	
Diagnosed with epilepsy at age:	How often do seizures occur:
Last seizure occurred:	
About how many total seizures have they had?	
What medications are they on now for seizures?	
What medications have they tried previously?	

The child has...	Describe (age, circumstance, treatment, problems afterwards)
<input type="checkbox"/> suffered a head injury	
<input type="checkbox"/> lost consciousness	
<input type="checkbox"/> been in a coma	
<input type="checkbox"/> had a temperature over 104° F for more than a few hours	

The child has been **hospitalized for medical issues** (illnesses, injuries, accidents, and operations).

Age	Reason

Previous Evaluations and Services Please check the tests/evaluations that have been completed as well as any services your child has received.

	Date(s)	With Whom, Results/Diagnosis, and Treatment
<input type="checkbox"/> No tests have been done		
<input type="checkbox"/> Blood Work		
<input type="checkbox"/> CT Scan		
<input type="checkbox"/> EEG		
<input type="checkbox"/> MRI or PET		
<input type="checkbox"/> Neurologist's exam		
<input type="checkbox"/> Genetic Testing		
<input type="checkbox"/> Hearing Testing		
<input type="checkbox"/> Vision Testing		
<input type="checkbox"/> Birth-to-Three or Head Start		
<input type="checkbox"/> Occupational Therapy		
<input type="checkbox"/> Physical Therapy		
<input type="checkbox"/> Speech/Language		
<input type="checkbox"/> School Testing		
<input type="checkbox"/> Other		
<input type="checkbox"/> Psychiatric		
<input type="checkbox"/> Psychological/Neuropsychological (e.g. outpatient, inpatient, residential services as well as evaluations)		

Family Information & History

Parent/Guardian Information:

Mother's Name _____ Age _____

Biological Adoptive Step Other _____

Home Phone _____

Cell Phone _____

Occupation _____

Highest Grade Completed _____

If stay-at-home mother, occupation prior to children _____

Major Health Problems? _____

Lives with the child? Yes No *If no, explain* _____

Father's Name _____ Age _____

Biological Adoptive Step Other _____

Home Phone _____

Cell Phone _____

Occupation _____

Highest Grade Completed _____

If stay-at-home father, occupation prior to children _____

Major Health Problems? _____

Lives with the child? Yes No *If no, explain* _____

Marital Status of Parents

Married, living together Unmarried, living together Separated Divorced

Never married, living apart Other _____

If **separated or divorced**, how old was the child when the separation occurred? _____

What was the child's response to the separation? _____

If divorced, please describe the legal/custody arrangements _____

The child has been **raised by**:

Biological mother

Biological father

Biological relatives

Step-mother

Step-father

Adoptive parents

Foster parents

Institutional care

Other: _____

If not raised by biological parents, please describe the circumstances and age(s) of other placements:

Please list the age and sex of **siblings** (including step- and half-siblings). No siblings

	Age & Sex of Siblings					
	Child 1:	Child 2:	Child 3:	Child 4:	Child 5:	Child 6:
Lives in Primary Residence with Child:						

Major family stressors or changes in the past year include: None

<input type="checkbox"/> Marital problems/conflict	<input type="checkbox"/> Divorce	<input type="checkbox"/> Family relocation
<input type="checkbox"/> Change of schools for this child	<input type="checkbox"/> Legal problems	<input type="checkbox"/> Parent job problems or change
<input type="checkbox"/> Significant illness accident, or death of family member. Explain.		
<input type="checkbox"/> Significant illness or accident of this client. Explain		
<input type="checkbox"/> Other:		
How much stress have these changes caused the child: <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		

Please check all that exist in the child's **biological family** (parents, siblings, grandparents, aunts, uncles, etc. For extended family, please also note which side of the family). [This information is **unknown**]

	Relative(s) (in relation to child)	Side of family		Describe
		Mother's	Father's	
<input type="checkbox"/> Attention problems		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Anxiety		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Autism/Asperger's		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Bipolar Disorder		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Brain or neurological disease		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Depression		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Developmental Delay		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Epilepsy or seizures		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Genetic disorder		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Learning disability		<input type="checkbox"/>	<input type="checkbox"/>	

<input type="checkbox"/> Intellectual Disability (formerly Mental Retardation)		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Obsessive Compulsive Disorder		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Speech/Language disorder		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Suicidality/Completed Suicide		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other		<input type="checkbox"/>	<input type="checkbox"/>	

Which of the child's biological relatives write or perform many activities with their **left-hand**?

- No-one Mother Father Sibling Grandparent(s)

Languages spoken in the home: _____

How is the child **disciplined**? _____

Check all of your child's usual **recreational activities and hobbies**.

<input type="checkbox"/> Reading	<input type="checkbox"/> TV	<input type="checkbox"/> Video games	<input type="checkbox"/> Sports	<input type="checkbox"/> Computer
<input type="checkbox"/> Collecting items	<input type="checkbox"/> Art	<input type="checkbox"/> Listening to music	<input type="checkbox"/> Playing music	<input type="checkbox"/> Writing
<input type="checkbox"/> Playing alone	<input type="checkbox"/> Playing with Others	<input type="checkbox"/> Other:		

SCHOOL

Current School _____

Address _____

Grade _____ Years Attended: _____

Type of School: Public Private Parochial Other: _____

Does your child receive formal **504 Accommodations**? YES NO

What services are they provided? _____

When were they first classified? _____

Does your child currently receive **Special Education Services**? YES NO

What is their Special Education Classification? _____

When were they first classified? _____

Child repeated a grade. Explain. _____

Child skipped a grade. Explain. _____

The child has been in the following classes: Resource Room Emotional/Behavioral
 LD Class (full time) LD class (part time) Advanced instruction Other

Explain _____

Does your child enjoy school? All or most of the time Sometimes Almost never

In school, your child

Gets along well with others and has friends OR Does not get along with other kids

Gets along well with the teacher OR Does not get along with the teacher

Describe any teacher concerns about your child's schoolwork or behavior. _____

The child's **current grades** are (choose the appropriate system):

1) A & B B & C C & D D & F

2) 90's 80's 70's 60's Below 60

3) Outstanding Good Satisfactory Improvement needed Unsatisfactory

Compared to previous years, these grades have: stayed the same improved declined

School or extra-curricular activities your child is involved in: _____

In the past year, how much school has your child missed due to illness or injury?

- Less than 2 weeks 2 to 4 weeks 5 to 8 weeks More than 8 weeks

Explain _____

Are you currently in dispute with the school? YES NO

Explain: _____

Are you being assisted by an attorney? YES NO

STRENGTHS & COMMENTS

Please describe your child's strengths. Also, you are welcome to add any additional comments, information, or concerns that have not been covered.

Medication History (continued) If you were unable to provide a complete list of your child's current and past medications on page 12, please continue the list below. Thank-you.

Medication	Dosage/ Frequency	To Treat...	Dates	Side-Effects/ Degree of Benefit