

# Neuropsychology History Form

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## Child and Adolescent Patient Information Questionnaire

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### General Information

Patient's Full Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Person Completing this Form: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email address: \_\_\_\_\_

Home Address: \_\_\_\_\_

Who referred you to our service? Please provide contact information: \_\_\_\_\_

Is this referral a result of or related to any legal or court proceedings? If so please provide name of attorney. \_\_\_\_\_

What is the primary language spoken at home? \_\_\_\_\_

What was the first language learned? \_\_\_\_\_

Is your child right-handed, left-handed, or ambidextrous? \_\_\_\_\_

Name of School: \_\_\_\_\_ Grade: \_\_\_\_\_ Primary Teacher: \_\_\_\_\_

Has your child had previous educational or neuropsychological testing? Yes / No

If Yes, where? \_\_\_\_\_ When? \_\_\_\_\_

Has your child had a speech and language evaluation? Yes / No

If Yes, where? \_\_\_\_\_ When? \_\_\_\_\_

*If you answered Yes to either of the above questions, please attach report(s).*

Please list any other healthcare providers involved in your child's care (e.g., neurologists, pediatricians or other physicians, psychologists, social workers, therapists, special educators, occupational therapists, etc.) in the space provided below, and attach associated reports if available.

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Please list the reason(s) your child is being referred for the evaluation:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### **Developmental History**

#### Pregnancy and Birth

Were there complications during pregnancy? Please describe: \_\_\_\_\_  
(e.g., high blood pressure, diabetes, hospitalizations)

Medications used during pregnancy? Please list: \_\_\_\_\_

**Yes No** Smoking? How much? \_\_\_\_\_ **Yes No** Drug Intake? Type?  
\_\_\_\_\_

**Yes No** Alcohol? How much? \_\_\_\_\_ How much?  
\_\_\_\_\_

Length of pregnancy? \_\_\_\_\_ (weeks) Age of mother at birth: \_\_\_\_\_ Birth weight: \_\_\_\_\_

Pregnancy/Birth/Delivery Complications? Please Describe \_\_\_\_\_

APGAR scores? \_\_\_\_\_ Length of hospital stay? Mother: \_\_\_\_\_ (days) Child: \_\_\_\_\_ (days)

#### Developmental Milestones

At what age did this child first do the following (indicate with year and month of age).

Turn over \_\_\_\_\_ Crawl \_\_\_\_\_ Stand Alone \_\_\_\_\_ Walk Alone \_\_\_\_\_

Walk Upstairs \_\_\_\_\_ First Words \_\_\_\_\_ First Phrases \_\_\_\_\_

Toilet Trained? **Yes No** If yes, Days? \_\_\_\_\_ Nights? \_\_\_\_\_

Did bed wetting or soiling occur after training? **Wetting Soiling** If yes, until what age? \_\_\_\_\_

#### Early Development and Medical History

**Yes No** Enjoyed cuddling

**Yes No** Fussy, irritable  
**Yes No** More active than other babies  
**Yes No** If child has siblings, was development different in any way? Explain. \_\_\_\_\_

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**Yes No** Has your child's medical history been normal? If no, please explain. \_\_\_\_\_

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**Yes No** Has your child received any medical or psychiatric diagnoses? Please explain: \_\_\_\_\_

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If yes, please describe:

- Yes No** Frequent ear infections. Starting at what age? \_\_\_\_\_
  - Yes No** Were ear tubes ever placed?
  - Yes No** Hearing problems? Last exam? \_\_\_\_\_
  - Yes No** Vision problems? Last exam? \_\_\_\_\_
  - Yes No** Headaches?
  - Yes No** Meningitis?
  - Yes No** Seizures?
  - Yes No** Asthma?
  - Yes No** Elevated lead level?
  - Yes No** Slow/fast growth?
  - Yes No** Head injury with or without loss of consciousness?
  - Yes No** Allergies?
  - Yes No** Hospitalizations?
  - Yes No** Physical/Sexual Abuse?
  - Yes No** Has your child ever been in therapy? Please explain. \_\_\_\_\_
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Please list any medications (including dosages) your child takes presently: \_\_\_\_\_

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When did you first become concerned about your child's development? \_\_\_\_\_

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What do you find most stressful or difficult about your child? \_\_\_\_\_

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Please place a mark (✓) next to behaviors that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her age.

**Sleeping and Eating**

- | Nightmares
- | Trouble sleeping
- | Eats poorly
- | Eats excessively
- | Excessive snoring during sleep

- | Overly attached to certain objects
- | Not affected by negative consequences
- | Drug abuse
- | Alcohol abuse
- | Sexually active
- | Dangerous to self or others (describe): \_\_\_\_\_

**Social Development**

- | Prefers to be alone
- | Excessively shy or timid
- | More interested in objects than in people
- | Difficulty making friends
- | Teased by other children
- | Bullies other children
- | Not sought out for friendship by peers
- | Difficulty seeing another person's point of view
- | Doesn't empathize with others
- | Overly trusting of others
- | Doesn't appreciate humor

- | Purposely harms or injures self (describe): \_\_\_\_\_

- | Talks about killing self (describe): \_\_\_\_\_

**Behavior**

- | Stubborn
- | Irritable, angry, or resentful
- | Frequent tantrums
- | Strikes out at others
- | Throws or destroys things
- | Lying
- | Stealing
- | Argues with adults
- | Low frustration threshold
- | Daredevil behavior
- | Runs away
- | Needs a lot of supervision
- | Impulsive (does things without thinking)
- | Poor sense of danger
- | Skips school
- | Seems depressed
- | Cries frequently
- | Excessively worried and anxious
- | Overly preoccupied with details

- | Unusual fears, habits or mannerisms (describe): \_\_\_\_\_

**Other Problems**

- | Bladder control problems (not during seizure)
- | Poor bowel control (soils self)
- | Motor/vocal tics
- | Overreacts to noises
- | Overreacts to touch
- | Excessive daydreaming and fantasy life
- | Problems with taste or smell

**Motor skills**

- | Poor fine motor coordination
- | Poor gross motor coordination

### Family History

Biological Mother: Current Age \_\_\_\_\_

Biological Father: Current Age \_\_\_\_\_

Name \_\_\_\_\_

Name \_\_\_\_\_

Occupation \_\_\_\_\_

Occupation \_\_\_\_\_

Highest grade completed \_\_\_\_\_

Highest grade completed \_\_\_\_\_

Any history of the following (please circle):

Any history of the following (please circle):

Learning problems

Learning problems

Speech problems

Speech problems

Behavior problems

Behavior problems

Medical problems

Medical problems

Emotional problems

Emotional problems

Drug or alcohol problems

Drug or alcohol problems

Parents are (choose one): Married Separated Divorced Living Together Mother Deceased Father Deceased

If separated or divorced, how old was the child when the separation occurred? \_\_\_\_\_

Child lives with (choose one): Both parents Mother Father Other

Who has legal custody? \_\_\_\_\_

Siblings:    Name                                      Age                                      Medical, social, academic, speech problems

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who else lives in the home? \_\_\_\_\_

Other than siblings, is there any family history of Learning Disabilities, Attention Deficit Hyperactivity Disorder (ADD/ADHD), emotional, behavioral, or neurological disorder? **Yes No**. Please explain:

\_\_\_\_\_

### Academic History

Child's current Grade: \_\_\_\_\_

School name: \_\_\_\_\_ **Public or Private?**

Street Address: \_\_\_\_\_  
City State Zip

School District: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

What preschool experience did your child have?

Were any problems detected in your child's kindergarten screening? **Yes No** Please explain.

Is your child in a regular classroom? **Yes No** Please explain.

Does your child have an IEP or 504 plan, or other modified learning program? **Yes No** Please explain.

Has your child ever received tutoring? **Yes No** Please explain

What are your child's typical grades?

What are your child's strongest and weakest points, academically?

Are you satisfied with your child's educational program? **Yes No** Please explain.

What are your child's primary strengths and weaknesses outside of academics?

What services does your child receive outside of school?

In what community or extracurricular activities is your child involved?

What are your child's favorite activities?

How does your child get along with other children?

Please describe your disciplinary techniques.

Have there been any recent stressors that you think may be contributing to your child's difficulties (e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, changes schools, family moved, family financial problems, remarriage, sexual trauma, other losses)?

Please provide any additional information which you would like us to know or which you feel would help us better understand your child.