

CHILD NEUROPSYCHOLOGICAL HISTORY

Child's Name _____ Date _____ Age ____ Birth date _____ Grade: _____
Parent/guardian Tel: (home) _____ (work) _____ (cell phone) _____
Name of person filling out this form _____ Relationship to child _____
Religion (optional) _____ Sex _____ Ethnic or racial background _____
Hand child uses for writing or drawing: Right Left Switches between them
Primary language spoken at home: _____ Secondary language _____
Previous diagnosis (1) _____ (2) _____
Who referred the child to our office? _____
Briefly describe the problem: _____

What specific concerns do you have?

(1) _____
(2) _____
(3) _____

SYMPTOM SURVEY

For each symptom that applies to the child, please underline. Compare the child to other children of the same age. Add any helpful comments next to the item.

1) PROBLEM SOLVING

Difficulty figuring out how to do new things	Difficulty solving problems a younger child can do
Difficulty making decisions	Disorganized in his/her approach to problems
Difficulty planning ahead	Difficulty doing things in the right order (sequencing)
Difficulty understanding explanations	Difficulty describing the steps involved in doing something
Difficulty changing a plan or activity	Difficulty switching from one activity to another activity
Is slow to learn new things	Easily frustrated

2) SPEECH, LANGUAGE, AND MATH SKILLS

Always talking	Difficulty speaking clearly	Difficulty finding the right word to say
Jumps from topic to topic	Rambles on without saying much	Odd or unusual language or vocal sounds
Doesn't understand at all	Can't follow two-part directions	Difficulty understanding normal conversation
Difficulty with writing	Difficulty with spelling	Difficulty reading letters or words
Difficulty with math	Other speech, language, or math problems: _____	

3) SPATIAL SKILLS

Confusion telling right from left	Doesn't know his/her colors	Problems drawing or copying
Difficulty dressing	Difficulty recognizing objects	Difficulty with puzzles, Legos, or blocks
Gets lost in familiar places	Doesn't pay attention to facial expressions	

4) AWARENESS AND CONCENTRATION

Mind appears to go blank at times Loses train of thought Attention starts out OK but can't keep it up
Difficulty concentrating on what others say, but can watch TV for long periods
Easily distracted by: Sounds / Sights / Physical sensations Other concentration problems: _____

5) MEMORY

Forgets where he/she leaves things	Forgets things that happened recently (e.g., last meal)
Forgets things that happened days/weeks ago	Forgets what he/she is supposed to be doing
Forgets names more than most people do	Forgets school assignments
Forgets instructions	Other memory problems: _____

6) MOTOR AND COORDINATION Indicate **Right side** (R) **Left side** (L) **Both sides** (B)

Poor fine motor skills	Clumsy	Drops things	Weakness	Tremor	Tics
Tight or spastic muscles	Poor Balance	Unusual walk	Odd movements (posturing)		

7) SENSORY Indicate **Right side** (R) **Left side** (L) **Both sides** (B)

Problems seeing objects	Loss of feeling	High pain threshold	Difficulty telling hot from cold
Problems hearing sounds	Difficulty smelling odors	Difficulty tasting food	
Overly sensitive to: Touch	Light	Noise	Other sensory problems: _____

8) PHYSICAL How Often?

Frequently complains of headaches or nausea _____ Has dizzy spells _____
Joints pains (where)? _____ Excessive tiredness _____
Frequent urination or drinking _____ Other physical problems: _____

9) BEHAVIOR (Please circle)

Risk-taking Aggressive Quiet Nervous Nightmares Night terrors Sleepwalks
Poor Attachment Bizarre behavior Resists change Poor Sleeping habits Poor Eating habits
Bedwetting BM in underwear Self-mutilates Self-stimulates Shy and withdrawn
Emotional Fearful Swears a lot Depressed Dependent Immature Unmotivated

Below circle all the descriptions of the child that have been present for at least the **past 6 months**.
These behaviors should occur more frequently than in other children of the same age.

Is very fidgety Can't remain seated Highly distractible Impulsive Can't wait for his/her turn
Steals things without people knowing Easily lies to others Sets fires Sexually violent
Often runs away from parents' home Won't go to school Starts fights with others
Rarely follows others' instructions Breaks into other people's property Destroys other people's property
Is cruel to animals Is cruel to family members Is cruel to other people Doesn't listen to adults

10) Overall, the child's symptoms developed: Slowly / Quickly. The symptoms occur: Occasionally / Often
11) Over the past 6 months the symptoms have: Gotten better / Stayed about the same / Worsened

PREGNANCY

- 12)** Mother's age at child's birth: _____ Father's age at child's birth: _____
13) Before the pregnancy, what medications (prescribed or over-the-counter) did the mother take?
List all medications used: _____
14) While pregnant, what medications (prescribed or over-the-counter) did the mother take?
List all medications used: _____
15) How often did the mother see her doctor during the pregnancy? Regularly / Rarely / Not at all
16) During the pregnancy, which of the following did the mother use?
Amount and Daily Frequency: Alcohol _____ Caffeine _____ Tobacco _____
Marijuana _____ Recreational drugs (cocaine, heroin, etc.) _____
17) During the pregnancy, the mother's diet was: Good / Poor. If poor, explain: _____
18) The mother's general health during the pregnancy was: Good / Poor If poor, explain: _____
19) About how much weight did the mother gain while she was pregnant? _____ Lbs.
20) During this pregnancy, circle all the mother had:
Accident Anemia Bleeding (severe or frequent spotting) Diabetes High blood pressure
Preeclampsia, eclampsia, or toxemia Psychological problems Surgery Vomiting (severe or frequent)
21) Number of pregnancies mother had prior to this one? Number of live births: _____ miscarriages: _____

BIRTH

- 22)** Was this child born: Early How early? ___ weeks; On time? ___ (38-42 weeks) Late How late? ___ weeks
23) How much did the baby weigh at birth? ___ Lbs. ___ oz. How many hours did the labor last? _____
24) The labor was: Easy Moderately difficult Very difficult. Medication given to help with delivery? _____
25) Were forceps used during delivery? Yes No List the baby's APGAR scores: 1st _____ 2nd _____
26) Was the baby born: Head first /Transverse /Posterior first /Breech birth /C-section /Vacuum extraction
27) Did the baby experience any of these: Fetal distress /Low placenta (Placenta previa) /Prolapsed cord
Premature separation of placenta (Abrupto placenta) /Cord wrapped around neck
28) Describe any other special problems the mother or child had during delivery: _____
29) At birth, did the baby: Have difficulty breathing? Yes No /Fail to cry? Yes No /Seem inactive? Yes No
30) If the parent noticed anything unusual when they first saw the baby, describe: _____
If the baby was born with any problems (congenital defects, large or small head, blue baby, bleeding in brain, etc, decribe: _____ How long did the baby stay in the hospital? _____
Describe any special problems that the baby had in the first few days following birth: _____
Describe any special care, treatment, or equipment the child was given after birth: _____

DEVELOPMENTAL HISTORY

31) For each area, indicate the child's development by circling one description. The "average" period is only a rough idea of what is average since every developmental milestone actually involves a range of several months (e.g. walking occurs approximately 9-18 months of age). Circle "early" or "late" only if you are sure the child's development was different from that of most other children.

MOTOR SKILLS:	Crawled:	Early	Average (6-9 month)	Late	
	Walked alone (2-3 steps):	Early	Average (9-18 month)	Late	
LANGUAGE:	Followed simple commands:	Early	Average (12-18 month)	Late	
	Used single-word sentences:	Early	Average (12-24 month)	Late	
SELF-HELP	Toilet trained:	Early	Average (13-36 month)	Late	Easy/Hard

32) List any other significant developmental problems: _____

33) Overall, the child's development was: Early Average Late

34) As an infant or toddler, did the child have poor muscle control of the: Neck Trunk Legs Arms

35) As an infant or toddler, did the child's muscles seem to be unusually tight or stiff? Yes No

36) As an infant or toddler, the child was: Too calm / inactive; Calm / reasonably active; Irritable /very active

37) As a toddler, the child was: Shy /inhibited; Neither shy nor outgoing; Very outgoing and liked people;

38) Did the baby have a poor appetite? Yes No Did the baby fail to gain weight steadily? Yes No

39) List the baby's illnesses or physical problems during the first year: _____

40) Has the child had a temperature of 104°F (40°C) or higher for more than a few hours? Yes / No

If yes, what age (s)? _____ How long did it last? _____

41) Has the child ever been hit hard on the head or suffered a head injury? Yes No

If yes, what age(s)? _____ Did the child lose consciousness? Yes No

How did it happen? _____

What problems did the child have (physical or mental) afterwards? _____

42) Has the child been diagnosed with seizures or epilepsy? Yes No

Which type? Febrile Absence Partial seizure Generalized seizure Unclassified type

If medication is used, which medication(s)? _____

43) Was the child ever in the hospital for an injury or operation? Yes No If yes, what age(s)? _____

What happened? _____

44) Has the child ever swallowed any poison, an object, or drug accidentally? Yes No

45) Did the child have frequent ear infections? Yes No If yes, what age? ____ How often / severe? _____

What treatment was provided? _____ PE tubes? _____

46) Please check all the following diseases or conditions the child has ever had:

Allergies Cerebral palsy Jaundice Mumps Anemia Chicken pox Kidney disorder Meningitis
Oxygen deprivation Asthma Colds (excessive) Leukemia Pneumonia Bleeding disorder Diabetes
Liver disorder Rheumatic fever Blood disorder Encephalitis Lung disorder Scarlet fever Measles
Enzyme deficiency Tuberculosis Broken bones Genetic disorder STD's Cancer Heart disorder
Metabolic disorder Whooping cough Other problems: _____

47) Has the child been sick: Much of the time / An average amount / Not much at all

48) List all current medications: 1) _____ 2) _____ 3) _____ 4) _____

49) What is the current child's: Height _____ ft. _____ in. Weight: _____ lbs.

50) When was the child's last medical check-up? _____

51) What therapies have been provided to the child? No therapies

Occupational therapy Physical therapy Psychological counseling Cognitive rehabilitation Speech therapy

FAMILY HISTORY

52) The child lives with: Biological parent(s); Biological parent & other; Relatives; Foster care; Adoptive parents

53) The family's income is: under \$10,000 \$10,000-\$29,999 \$30,000-\$50,000 over \$50,000

54) Is the child's biological mother living? _____ If deceased, explain: _____

a. Her age? _____ b. What is her level of education? _____ c. Her occupation? _____

d. Does she live in the same house as the child? Yes No e. How often does she see the child? _____

g. How involved is the mother in the child's upbringing? Very Somewhat Not at all

h. Did mother have a learning disability or other problems during school years? Yes No What: _____

i. What are the mother's hobbies? _____

55) Is the child's biological father living? _____ If deceased, explain: _____

a. His age? _____ b. What is his level of education? _____ c. His occupation? _____

d. Does he live in the same house as the child? Yes No e. How often does he see the child? _____

- f. How involved is the father in the child's upbringing? Very Somewhat Not at all
 g. Did father have a learning disability or other problems when he was in school? What? _____
 h. What are the father's hobbies? _____

56) Please list the names, ages, and grade (or job) of the child's brothers and sister:

Name	Age	Grade or job	Learning challenges	Disabilities
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

57) Has anyone in the child's biological family (including parents, grandparents, siblings, aunts & uncles) ever had any of the following:

Which relative? Describe the problem briefly

Brain disease _____	Developmental delay _____
Epilepsy or seizures _____	Learning disability _____
Mental retardation _____	Neurological disease _____
Psychological problems _____	Reading or spelling difficulties _____
Speech or language problems _____	

58) Which of the child's biological relatives are left handed? No one Mother Father Siblings Grandparent(s)

59) How is the child disciplined? _____

60) List the child's usual recreational activities and hobbies: _____

61) Have there been any major family stresses or changes in the past year (e.g. moving with change of school, divorce, significant illness, etc)? Yes No If yes, explain: _____

How much stress has these changes caused the child? (circle one) None Mild Moderate Severe

SCHOOL HISTORY

62) The child's Grade school: _____ Middle school: _____ High School: _____

63) Has the child ever repeated a grade? Yes No If yes, which grade? _____ Why? _____

64) Has the child ever been in a special class, or special services (e.g. resource room, dyslexia class)? Yes No
 If yes, describe the special class: _____ Is the child receiving special services now? Yes No

65) Does the child like school? Most of the time Some of the time Almost never

66) Does the child: Have problems with other children in class? Yes No

Have problems making friends in school? Yes No

Have problems getting along with teachers? Yes No

Tend to get sick in the morning before school? Yes No

67) Describe the teacher's concerns about the child's schoolwork or behavior: _____

68) What kind of grades has the child received in the past year? A's & B's B's & C's C's & D's D's & F's

Or Outstanding Good Satisfactory Improvement needed Unsatisfactory

Are these grades different from previous years? Yes No

69) In which subject(s) does the child do best? _____

70) Which subject(s) are the most difficult? _____

71) In the past year, how much school has the child missed? Less than 2 weeks 2 to 4 weeks 5 to 8 weeks

Briefly describe the reasons if the child has missed a lot of school: _____

72) Does the child seem to have a "school phobia"? Yes No If yes, explain: _____

83) Who are the other professionals that know your child, are very familiar with the child's problems that we can contact (physician, counselor, teacher)?

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Profession: _____ Profession: _____

 Parent or Guardian's signature

 Date