PEDIATRIC NEUROPSYCHOLOGY SERVICES, PLLC

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Background Information Form- Adult

Patient's Name:
_____

Name of person filling out this questionnaire:
_____

Reason you are requesting this evaluation:
_____
_____
_____

In my opinion, the major cause of the patient's difficulties is:
_____
_____
_____

Describe some of the patient's strengths:
_____
_____
_____

Describe some of the patient's weaknesses:
_____
_____
_____

Names and ages of family members living with patient:
_____
_____
_____

What medications does the patient currently take?
_____
_____
_____

Is the patient currently in school?

_____

Is the patient currently employed? If so, where?

_____
_____
_____

Please list the history of the patient's employment (if applicable):

_____
_____
_____
_____

Are there any significant family or marital conflicts? Explain:

_____
_____
_____

Pregnancy and Birth History

Age at delivery of mother _____ and father _____?

Any known health problems of mother during pregnancy?

_____
_____
_____

List any medications, tobacco use, alcohol use or drugs taken by mother during pregnancy:_____

Delivery was vaginal _____ Cesarean _____ (reason _____)

Baby was full term _____ or premature _____ (weeks gestation)

Birth Weight _____ lb. _____ oz.

Was labor prolonged?_____(length of time =_____)

Any birth complications?

_____

Did baby breathe spontaneously? ____oxygen required? _____

Apgar scores if known _____ In Intensive Care Nursery?_____

How old was baby at discharge from the hospital after birth? _____

Medical problems after discharge:_____

Baby was_____(fussy/colicky/easy-going)

Sleep problems?_____

Eating problems?_____

Any other problems in first few months? _____

Developmental History

Motor

Approximate age sat alone _____crawled_____stood alone_____walked alone_____

Handedness: right _____ left _____ both _____ (explain)

Was physical therapy ever necessary? (when and why?)
_____

Was occupational therapy ever necessary? (when and why?)
_____

Speech/Language

Age spoke first word _____ put 2—3 words together _____

Speech delays/problems (e.g., stutters, difficult to understand)?_____
_____

Oral-motor problems (e.g., late drooling, poor sucking, poor chewing)? (describe)_____
_____

Was speech/language therapy ever necessary? _____

Was the patient slow to learn the alphabet? _____ name colors? ____ count? _____

Other language spoken at home (besides English)?_____

Besides English the patient is fluent in _____

Toileting

Age when toilet trained _____

Problems with bedwetting? Urine accidents? Soiling? Until what age? _____

Any current problem?_____

Any problems with the patient's personal hygiene currently?
_____
_____

Social Behavior

Does the patient have friends? _____keep friends? _____

understand gestures? _____have a good sense of humor? _____

understand social cues well?_____have problems with peer pressure (e.g., alcohol or drug use)? _____

Medical History

Has vision been checked within the last year? _____
Any problems:_____

Has hearing been checked within the last year? _____
Any problems:_____

CT, MRI, or EEG obtained?_____Date:_____ Results: _____

List serious illnesses/injuries/hospitalizations/surgeries

Date	Incident (explain)
_____	_____
_____	_____
_____	_____
_____	_____

Is there a history of:

failure-to-thrive? _____
febrile seizures? (fever associated) _____
epilepsy? _____
staring spells? _____
lead poisoning/toxic ingestion? _____
meningitis or encephalitis? _____
asthma? _____
allergies? _____
diabetes? _____
loss of consciousness? _____
abdominal pains/vomiting? _____
when do they occur? _____
headaches? _____
when do they occur? _____
frequent ear infections? _____
were ear tubes necessary? _____
age when tubes placed_____
sleep difficulties? _____
eating difficulties or eating disorder? _____
tics/twitching? _____
repetitive/stereotypic movements? _____
impulsivity? _____
temper tantrums? _____
nail biting? _____
clumsiness? _____
head banging?_____
self-injurious behavior?_____

Describe head injuries: (e.g., date, type, loss of consciousness, resulting changes in behavior?)_____
_____

Is there a family history of learning difficulties?
_____
_____

Is there a family history of neurological illness?
_____
_____

Is there a family history of psychiatric disorder?
_____
_____

Does anyone else in the family have a problem similar to the patient's reason for referral?

_____
_____

Educational History

Previous schools attended and age:

_____
_____
_____
_____
_____

Current school or college (if applicable):

_____

Grade:_____

Any grades that were skipped or repeated?_____

History of academic difficulties:

Grade:	**Problems Noted**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Prior Psychological History

Has the patient previously had direct contact with any neurologist, psychologist, psychiatrist, clinic or private agency?_____

Date	Name of professional
_____	_____
_____	_____
_____	_____
_____	_____

Has the patient ever been hospitalized in a psychiatric unit?_____

Date	Name of hospital	Diagnosis (if known)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Prior Educational or Psychiatric Diagnoses:

Age:	**Diagnosis**
_____	_____
_____	_____
_____	_____

Any other areas of concern not noted above:

_____
_____
_____
_____
_____
_____