PEDIATRIC NEUROPSYCHOLOGY SERVICES, PLLC
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Background Information Form
Reassessment For Prior Patients Only

(Please only complete if your child was assessed by Dr. Lurie in earlier years)

Child's Name:
____

Name of person filling out this questionnaire:
____

Reason you are requesting this reassessment:
____
____
____

Describe some of your child's current strengths:
____
____
____

Describe some of your child's current weaknesses:
____
____
____

Any specific concerns since the prior assessment:
____
____
____
____
____
____

Names and ages of family members living with child:
____
____
____

What medications does the child currently take?
____
____
____

Are there any significant family or marital conflicts? Explain
____
____

Social Behavior

Does your child 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: _____________

Any problems with the child's personal hygiene currently?
____
____

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

List serious illnesses/injuries/hospitalizations/surgeries

Date Incident (explain)
______ ____
______ ____
______ ____
______ ____

Is there a history of:

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?_______________________________________

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 your child'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?__________

Current Placement: regular __ resource __ special education __

History of academic difficulties:

Grade:	**Problems Noted?**
_______	____
_______	____
_______	____
_______	____
_______	____
_______	____

Prior Psychological History

Has your child previously had direct contact with any neurologist, psychologist, psychiatrist, clinic or private agency?______________________________

Date	Name of professional
_______	____
_______	____
_______	____

Has your child 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:

____
____
____
____
____
____