PEDIATRIC NEUROPSYCHOLOGY SERVICES, PLLC

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Background Information Form- Child

Child's Name:
_____

Name of person filling out this questionnaire:
_____

Reason you are requesting this evaluation:
_____
_____
_____

Who referred you to my practice?_____

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

Describe some of your child's strengths:
_____
_____
_____

Describe some of your child's weaknesses:
_____
_____
_____

What would <u>your child</u> describe as his or her strengths?
_____
_____

What would <u>your child</u> describe as his or her weaknesses?
_____
_____

Names, gender, and ages of family members living with child:

_____
_____
_____

What medications does the child currently take?

_____
_____
_____

Do both parents agree about the nature and causes of the problem?

_____
_____

Has your child experienced death or separation from a loved one? Explain

_____
_____

If parents are divorced, where does the child live and what are the custody arrangements?

_____
_____

Are there any significant family or marital conflicts? Explain

_____
_____

PREGNANCY AND BIRTH HISTORY

Age at delivery of mother _____ and father _____? How many prior pregnancies?_____How many prior miscarriages? _____ Was a fertility specialist consulted? _____ Procedures? _____

Any known health problems of mother during pregnancy? _____

vaginal bleeding? _____ toxemia? _____hypertension?_____

Gestational diabetes? _____ trauma? _____

fever/rash? (e.g., flu,measles?) _____antibiotics? _____

depression or other emotional problems? _____ injury? _____

Other? _____

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? (e.g., feet first/cord around neck/meconium staining/lacking oxygen-blue/jaundice-yellow) _____

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 (e.g., jaundice, fever, transfusion, surgery) _____

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_____

Was your child slow to develop motor skills or awkward compared to siblings/friends (e.g., running, skipping, climbing, biking, playing ball? _____

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 child slow to learn the alphabet? _____ name colors? _____ count? _____

Other language spoken at home (besides English)?_____

Besides English my child is fluent in _____

Toileting

Age when toilet trained _____

Problems with bedwetting? urine accidents? soiling? Until what age? _____

Any current problem?_____

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

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)? _____

What does your child love to do for fun?

_____
_____

How does your child get along with:

Mother_____Father_____
Brothers or Sisters_____

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_____Reason:_____
Date(s):_____Results: _____

List serious illnesses/injuries/hospitalizations/surgeries

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

Is there a history of:

failure-to-thrive as an infant? _____
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? Describe:_____
eating difficulties or eating disorder?_____Describe:_____
_____
tics? _____
repetitive/stereotypic movements? _____
clumsiness? _____
head banging?_____
self-injurious behavior?_____Describe:_____

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 your child's reason for referral?
_____
_____

EDUCATIONAL HISTORY

Previous schools attended, grade, 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: