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:
_____
_____
_____

What would your child describe as his or her strengths?
_____
_____

What would your child describe as his or her weaknesses?
_____
_____

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

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

_____
_____
_____

What medications does the child currently take?

_____
_____
_____

Are there any significant family or marital conflicts? Explain

_____
_____

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

_____
_____

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:

_____
_____
_____
_____
_____
_____
_____