

# CHILD NEUROPSYCHOLOGICAL HISTORY

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address (Street, City, State, Zip): \_\_\_\_\_

Parent's or guardian phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Religion \_\_\_\_\_

Sex \_\_\_\_\_ Ethnic or racial background \_\_\_\_\_

Grade and school \_\_\_\_\_

Special Placement (if any) \_\_\_\_\_

Hand child uses for writing or drawing: Right \_\_\_\_\_ Left \_\_\_\_\_ Switches between them \_\_\_\_\_

Primary language \_\_\_\_\_ Secondary language \_\_\_\_\_

Medical diagnosis (if any) (1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

(4) \_\_\_\_\_

Who referred the child for this testing? \_\_\_\_\_

Briefly describe the problem(s)

(1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

(4) \_\_\_\_\_

What specific questions would you like answered by this evaluation?

(1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

(4) \_\_\_\_\_

## THIS FORM HAS BEEN COMPLETED BY:

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

## SYMPTOM SURVEY

For each symptom that applies to the child, place a check in the box. Compare the child to other children of the same age. Then, check if this is a NEW symptom (within the past year OR after the injury/illness) or an OLD symptom (over one year OR before the injury or illness). Add any comments next to the item.

### 1) PROBLEM SOLVING

- | √                        | New | Old |  |
|--------------------------|-----|-----|--|
| <input type="checkbox"/> | ___ | ___ | Difficulty figuring out how to do new things                         |
| <input type="checkbox"/> | ___ | ___ | Difficulty making decisions  |
| <input type="checkbox"/> | ___ | ___ | Difficulty planning ahead  |
| <input type="checkbox"/> | ___ | ___ | Difficulty solving problems a younger child can do                   |
| <input type="checkbox"/> | ___ | ___ | Disorganized in his/her approach to problems                         |
| <input type="checkbox"/> | ___ | ___ | Difficulty understanding explanations                                |
| <input type="checkbox"/> | ___ | ___ | Difficulty doing things in the right order (sequencing)              |
| <input type="checkbox"/> | ___ | ___ | Difficulty verbally describing the steps involved in doing something |
| <input type="checkbox"/> | ___ | ___ | Difficulty completing an activity in a reasonable period of time     |
| <input type="checkbox"/> | ___ | ___ | Difficulty changing a plan or activity when necessary                |
| <input type="checkbox"/> | ___ | ___ | Is slow to learn new things  |
| <input type="checkbox"/> | ___ | ___ | Difficulty switching from one activity to another activity           |
| <input type="checkbox"/> | ___ | ___ | Easily frustrated  |
| <input type="checkbox"/> | ___ | ___ | Other problem solving difficulties _____                             |

### 2) SPEECH, LANGUAGE, AND MATH SKILLS

- | √                        | New | Old |   |
|--------------------------|-----|-----|---|
| <input type="checkbox"/> | ___ | ___ | Difficulty speaking clearly                     |
| <input type="checkbox"/> | ___ | ___ | Difficulty finding the right word to say        |
| <input type="checkbox"/> | ___ | ___ | Not talking                                     |
| <input type="checkbox"/> | ___ | ___ | Rambles on and on without saying much           |
| <input type="checkbox"/> | ___ | ___ | Jumps from topic to topic                       |
| <input type="checkbox"/> | ___ | ___ | Odd or unusual language or vocal sounds         |
| <input type="checkbox"/> | ___ | ___ | Difficulty understanding what others are saying |
| <input type="checkbox"/> | ___ | ___ | Difficulty understanding what h/she is reading  |
| <input type="checkbox"/> | ___ | ___ | Difficulty writing letters or words             |
| <input type="checkbox"/> | ___ | ___ | Difficulty reading letters or words             |
| <input type="checkbox"/> | ___ | ___ | Difficulty with spelling                        |
| <input type="checkbox"/> | ___ | ___ | Difficulty with math                            |
| <input type="checkbox"/> | ___ | ___ | Other speech, language, or math problems: _____ |

### 3) SPATIAL SKILLS

- | √                        | New | Old |   |
|--------------------------|-----|-----|---|
| <input type="checkbox"/> | ___ | ___ | Confusion telling right from left   |
| <input type="checkbox"/> | ___ | ___ | Has difficulty with puzzles, Legos, blocks, or similar games                    |
| <input type="checkbox"/> | ___ | ___ | Problems drawing or copying   |
| <input type="checkbox"/> | ___ | ___ | Doesn't know his/her colors   |
| <input type="checkbox"/> | ___ | ___ | Difficulty dressing (not due to physical disability)                            |
| <input type="checkbox"/> | ___ | ___ | Problems finding his/her way around places he/she has been to before            |
| <input type="checkbox"/> | ___ | ___ | Difficulty recognizing objects  |
| <input type="checkbox"/> | ___ | ___ | Seems unable to recognize facial or body expressions of disapproval or emotions |
| <input type="checkbox"/> | ___ | ___ | Gets lost easily  |
| <input type="checkbox"/> | ___ | ___ | Other spatial problems: _____   |

**4) AWARENESS AND CONCENTRATION**

- |   |     |     |  |            |                                    |
|---|-----|-----|--|------------|------------------------------------|
| √ | New | Old |  |            |                                    |
| □ | ___ | ___ | Easily distracted by:  | Sounds ___ | Sights ___ Physical Sensations ___ |
| □ | ___ | ___ | Mind appears to go blank at times  |            |                                    |
| □ | ___ | ___ | Loses train of thought   |            |                                    |
| □ | ___ | ___ | Difficulty concentrating on what others say, but can sit in front of a TV for long periods |            |                                    |
| □ | ___ | ___ | Attention starts out OK but can't keep it up   |            |                                    |
| □ | ___ | ___ | Other attention or concentration problems:   | _____      |                                    |

**5) MEMORY**

- |   |     |     |   |       |
|---|-----|-----|---|-------|
| √ | New | Old |   |       |
| □ | ___ | ___ | 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**

- |   |     |     |  |                                |      |            |
|---|-----|-----|--|--------------------------------|------|------------|
| √ | New | Old |  | Check the side this occurs on: |      |            |
|   |     |     |  | Right                          | Left | Both Sides |
| □ | ___ | ___ | Poor fine motor skills (e.g., using a pencil or crayon)  | ___                            | ___  | ___        |
| □ | ___ | ___ | Clumsy   | ___                            | ___  | ___        |
| □ | ___ | ___ | Weakness   | ___                            | ___  | ___        |
| □ | ___ | ___ | Tremor   | ___                            | ___  | ___        |
| □ | ___ | ___ | Muscles are tight or spastic                             | ___                            | ___  | ___        |
| □ | ___ | ___ | Odd movements (posturing, peculiar hand movements, etc.) | ___                            | ___  | ___        |
| □ | ___ | ___ | Drops things more than most children                     |                                |      |            |
| □ | ___ | ___ | Has an unusual walk                                      |                                |      |            |
| □ | ___ | ___ | Problems running   |                                |      |            |
| □ | ___ | ___ | Balance problems   |                                |      |            |
| □ | ___ | ___ | Other motor or coordination problems:                    | _____                          |      |            |

**7) SENSORY**

- |   |     |     |  |                                |      |            |
|---|-----|-----|--|--------------------------------|------|------------|
| √ | New | Old |  | Check the side this occurs on: |      |            |
|   |     |     |  | Right                          | Left | Both Sides |
| □ | ___ | ___ | Needs to squint or move closer to page to read     | ___                            | ___  | ___        |
| □ | ___ | ___ | Problems seeing objects                            | ___                            | ___  | ___        |
| □ | ___ | ___ | Loss of feeling                                    |                                |      |            |
| □ | ___ | ___ | Problems hearing sounds                            |                                |      |            |
| □ | ___ | ___ | Difficulty telling hot from cold                   |                                |      |            |
| □ | ___ | ___ | Difficulty smelling odors                          |                                |      |            |
| □ | ___ | ___ | Difficulty tasting food                            |                                |      |            |
| □ | ___ | ___ | Overly sensitive to: Touch ___ Light ___ Noise ___ |                                |      |            |
| □ | ___ | ___ | Other sensory problems:                            | _____                          |      |            |



**8) PHYSICAL**

√	New	Old		How often?
<input type="checkbox"/>	___	___	Frequently complains of headaches or nausea	_____
<input type="checkbox"/>	___	___	Has dizzy spells	_____
<input type="checkbox"/>	___	___	Has pains in joints. <i>Where?</i> _____	_____
<input type="checkbox"/>	___	___	Excessive tiredness	
<input type="checkbox"/>	___	___	Frequent urination or drinking	
<input type="checkbox"/>	___	___	Other physical problems: _____	

**9) BEHAVIOR**

√	New	Old	
<input type="checkbox"/>	___	___	Aggressive
<input type="checkbox"/>	___	___	Attached to things, not people
<input type="checkbox"/>	___	___	Bedwetting
<input type="checkbox"/>	___	___	Bizarre behavior
<input type="checkbox"/>	___	___	Bowel movements in underwear
<input type="checkbox"/>	___	___	Dependent
<input type="checkbox"/>	___	___	Depressed
<input type="checkbox"/>	___	___	Eating habits are poor
<input type="checkbox"/>	___	___	Emotional
<input type="checkbox"/>	___	___	Fearful
<input type="checkbox"/>	___	___	Immature
<input type="checkbox"/>	___	___	Nervous
<input type="checkbox"/>	___	___	Nightmares, night terrors, sleepwalks
<input type="checkbox"/>	___	___	Quiet
<input type="checkbox"/>	___	___	Resists change
<input type="checkbox"/>	___	___	Risk-taking
<input type="checkbox"/>	___	___	Self-mutilates
<input type="checkbox"/>	___	___	Self-stimulates
<input type="checkbox"/>	___	___	Shy and withdrawn
<input type="checkbox"/>	___	___	Sleeping habits are poor
<input type="checkbox"/>	___	___	Swears a lot
<input type="checkbox"/>	___	___	Unmotivated
<input type="checkbox"/>	___	___	Other unusual behavior _____

Below, check 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.

- \_\_\_\_\_ Careless
- \_\_\_\_\_ Is easily distracted
- \_\_\_\_\_ Has a hard time concentrating for long periods
- \_\_\_\_\_ Rarely follows others' instructions
- \_\_\_\_\_ Doesn't listen to other people
- \_\_\_\_\_ Goes from one activity to another without finishing anything
- \_\_\_\_\_ Seems like he/she frequently is losing things that are needed for school
- \_\_\_\_\_ Forgetful in daily activities
- \_\_\_\_\_ Seems disorganized
- \_\_\_\_\_ Is very fidgety
- \_\_\_\_\_ Can't remain seated
- \_\_\_\_\_ Can't wait for his/her turn when playing with others
- \_\_\_\_\_ Answers before he/she hears the whole question

- \_\_\_\_\_ Frequently makes noise when playing
- \_\_\_\_\_ Seems like he/she is always talking
- \_\_\_\_\_ Is often rude or interrupts others
- \_\_\_\_\_ Seems like driven by a motor
- \_\_\_\_\_ Can't seem to play quietly
- \_\_\_\_\_ Frequently does dangerous things without considering the consequences
- \_\_\_\_\_ Loses temper easily
- \_\_\_\_\_ Argues with adults
- \_\_\_\_\_ Refuses to comply with requests
- \_\_\_\_\_ Easily blames others for mistakes and problems
- \_\_\_\_\_ Easily annoyed or irritated
- \_\_\_\_\_ Seems angry and resentful
- \_\_\_\_\_ Steals things without people knowing on several occasions
- \_\_\_\_\_ Often runs away from his parents' home and stays away overnight
- \_\_\_\_\_ Easily lies to others
- \_\_\_\_\_ Fire setting
- \_\_\_\_\_ Doesn't go to school
- \_\_\_\_\_ Breaks into other people's property
- \_\_\_\_\_ Destroys other people's property in some manner other than by fire
- \_\_\_\_\_ Is cruel to animals
- \_\_\_\_\_ Has forcible sexual relations with others
- \_\_\_\_\_ When fighting, has used a weapon on more than one occasion
- \_\_\_\_\_ Starts fights with others
- \_\_\_\_\_ Will steal directly from people
- \_\_\_\_\_ Is cruel to other people

- 10) Overall, the child's symptoms have developed: \_\_\_\_\_ Slowly \_\_\_\_\_ Quickly
- 11) The symptoms occur: \_\_\_\_\_ Occasionally \_\_\_\_\_ Often
- 12) Over the past 6 months the symptoms have: \_\_\_\_\_ Stayed about the same \_\_\_\_\_ Worsened

**PREGNANCY**

- 13) Mother's age at birth: \_\_\_\_\_ Father's age at birth: \_\_\_\_\_
- 14) **Before** the pregnancy, what medications (prescribed or over-the-counter) did the mother take?  
List all medications used: \_\_\_\_\_
- 15) **While** pregnant, what medications (prescribed or over-the-counter) did the mother take?  
List all medications used: \_\_\_\_\_
- 16) How often did the mother see her doctor during the pregnancy?  
Regularly (as scheduled by the doctor) \_\_\_\_\_ Rarely \_\_\_\_\_ Not at all \_\_\_\_\_
- 17) During the pregnancy, which of the following did the mother use?

	<b>Amount and Daily Frequency</b>
_____ Alcohol	_____
_____ Caffeine (coffee, colas, etc.)	_____
_____ Marijuana	_____

\_\_\_\_ Recreational drugs (cocaine, heroin, etc.)  
\_\_\_\_ Tobacco

\_\_\_\_\_  
\_\_\_\_\_

18) During pregnancy, the mother's diet was: Good \_\_\_\_ Poor \_\_\_\_  
If poor, explain: \_\_\_\_\_

19) The mother's general physical health during the pregnancy was: Good \_\_\_\_ Poor \_\_\_\_  
If poor, explain: \_\_\_\_\_

20) About how much weight did the mother gain while she was pregnant? \_\_\_\_\_ lbs.

21) During this pregnancy, check all the mother had:

- \_\_\_\_ Accident
- \_\_\_\_ Anemia
- \_\_\_\_ Bleeding (severe or frequent spotting)
- \_\_\_\_ Diabetes
- \_\_\_\_ High blood pressure
- \_\_\_\_ Illnesses or infections
- \_\_\_\_ Preeclampsia, eclampsia, or toxemia
- \_\_\_\_ Psychological problems
- \_\_\_\_ Surgery
- \_\_\_\_ Vomiting (severe or frequent)

22) How many pregnancies did the mother have prior to this one?

Number of live births: \_\_\_\_\_  
Number of miscarriages: \_\_\_\_\_  
Number of abortions: \_\_\_\_\_

## BIRTH

23) Was the child born:

Early \_\_\_\_\_ How early? \_\_\_\_\_ weeks  
On time \_\_\_\_\_ (38-42 weeks)  
Late \_\_\_\_\_ How late? \_\_\_\_\_ weeks

24) How much did the baby weight at birth? \_\_\_\_\_ lbs. \_\_\_\_\_ oz. OR \_\_\_\_\_ gms

25) How long did the labor last? \_\_\_\_\_

26) The labor was: Easy \_\_\_\_\_ Moderately difficulty \_\_\_\_\_ Very difficult \_\_\_\_\_

27) What type of medication was the mother given to help with delivery? None \_\_\_\_\_  
Demerol \_\_\_\_\_ Gas \_\_\_\_\_ Regional nerve (spinal) block \_\_\_\_\_ Tranquilizer \_\_\_\_\_ Epidural \_\_\_\_\_

28) Were forceps used during delivery? Yes \_\_\_\_\_ No \_\_\_\_\_

29) Was the baby born:

Head first \_\_\_\_\_ Transverse (crosswise) \_\_\_\_\_ Posterior first \_\_\_\_\_  
Breech birth \_\_\_\_\_ Caesarean section \_\_\_\_\_ Vacuum extraction \_\_\_\_\_  
Other: \_\_\_\_\_



30) Did the baby experience any of these problems:  
 Fetal distress \_\_\_\_\_ Low placenta (Placenta previa) \_\_\_\_\_ Prolapsed cord \_\_\_\_\_  
 Premature separation of the placenta (Abruptio placenta) \_\_\_\_\_

31) Describe any other special problems the mother or child had during delivery:  
 \_\_\_\_\_  
 \_\_\_\_\_

32) At birth, did the baby:  
 Have difficulty breathing? Yes \_\_\_ No \_\_\_  
 Fail to cry? Yes \_\_\_ No \_\_\_  
 Appear Inactive? Yes \_\_\_ No \_\_\_

33) List the baby's Apgar scores: 1<sup>st</sup> \_\_\_ 2<sup>nd</sup> \_\_\_

34) If the father or mother noticed anything unusual when they first saw the baby, describe:  
 \_\_\_\_\_  
 \_\_\_\_\_

35) If the baby was born with any problems (congenital defects, large or small head, blue baby, bleeding in brain, etc.), describe: \_\_\_\_\_  
 \_\_\_\_\_

36) Describe any special problems that the baby had in the first few days or weeks following birth:  
 \_\_\_\_\_  
 \_\_\_\_\_

37) Describe any special care, treatment, or equipment the child was given after birth:  
 \_\_\_\_\_

38) How long did the baby stay in the hospital? \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

39) 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.

**GROSS MOTOR SKILLS**

Crawled	Early	Average (6-9 months)	Late
Walked alone (2-3 steps)	Early	Average (9-18 months)	Late
Pedals a tricycle	Early	Average (32-26 months)	Late

**LANGUAGE**

Followed simple commands	Early	Average (12-18 months)	Late
Used single-word	Early	Average (12-24 months)	Late
Said phrases	Early	Average (24-36 months)	Late
Names primary colors	Early	Average (36 to 48 months)	Late

**ADAPTIVE**

Toilet trained	Early	Average (13-36 months)	Late
Feeds self with spoon	Early	Average (21-24 months)	Late
Takes off open shirt/coat	Early	Average (18-24 months)	Late

40) List any other significant developmental problems:

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41) Overall, the child's development was:

Early \_\_\_\_ Average \_\_\_\_ Late \_\_\_\_

42) As an infant or toddler, did the child have poor muscle control (i.e., weakness) of the:

Neck \_\_\_\_ Trunk \_\_\_\_ Legs \_\_\_\_ Arms \_\_\_\_

43) As an infant or toddler, did the child's muscles seem to be unusually tight or stiff?

Yes \_\_\_\_ No \_\_\_\_ If yes, describe: \_\_\_\_\_

44) Toilet training was:

Easy \_\_\_\_ Difficult \_\_\_\_

45) As an infant, to a significant degree, were any of the following present during the first two years of life?

- Did not enjoy cuddling \_\_\_\_\_
- Was not calmed by being held or stroked \_\_\_\_\_
- Difficult to comfort \_\_\_\_\_
- Colic \_\_\_\_\_
- Excessive restlessness \_\_\_\_\_
- Poor sleep \_\_\_\_\_
- Head banging \_\_\_\_\_
- Difficult nursing \_\_\_\_\_

46) Please rate the following behaviors as you child appeared during infancy and toddlerhood:

Activity Level – How active has your child been from an early age? \_\_\_\_\_

Distractibility – How well did your child pay attention? \_\_\_\_\_

Adaptability – How well did your child deal with transition and change? \_\_\_\_\_

Approach/Withdrawal – How well did your child respond to new things (i.e. people and places)? \_\_\_\_\_

Mood – What was your child's basic mood? \_\_\_\_\_

Regularity – How predictable was your child in patterns of sleep, appetite, routines, etc.? \_\_\_\_\_

**HEALTH HISTORY**

47) Did the child have a good appetite as a baby? Yes \_\_\_\_ No \_\_\_\_

48) Did the child fail to gain weight steadily as a baby? Yes \_\_\_\_ No \_\_\_\_



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

\_\_\_\_\_

50) 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)? \_\_\_\_\_ and how long did it last? \_\_\_\_\_

51) 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?

\_\_\_\_\_

52) Has the child been diagnosed with seizures or epilepsy?

If yes, which type? Partial seizure \_\_\_ Generalized seizure \_\_\_ Unclassified type \_\_\_

If medication is used, what medication(s)? \_\_\_\_\_

Has the child ever had a bad reaction to this medicine? Yes \_\_\_ No \_\_\_

If yes, describe: \_\_\_\_\_

Did the child ever have a seizure due to a fever or unknown cause? Yes \_\_\_ No \_\_\_

If yes, describe (age, nature of seizure): \_\_\_\_\_

53) Was the child ever in the hospital for an accident, injury, or operation? Yes \_\_\_ No \_\_\_

If yes, what age(s)? \_\_\_\_\_ What happened? \_\_\_\_\_

\_\_\_\_\_

54) Has the child ever swallowed any poison, non-food, or drug accidentally? Yes \_\_\_ No \_\_\_

If yes, what age(s)? \_\_\_\_\_ What happened? \_\_\_\_\_

55) Did the child have frequent ear infections? Yes \_\_\_ No \_\_\_

If yes, what age(s)? \_\_\_\_\_ How often and severe? \_\_\_\_\_

What treatment was provided? \_\_\_\_\_

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

___ Allergies	___ Cerebral Palsy	___ Jaundice	___ Mumps
___ Anemia	___ Chicken Pox	___ Kidney Disorder	___ Oxygen deprivation
___ Asthma	___ Colds (excessive)	___ Leukemia	___ Pneumonia
___ Bleeding disorder	___ Diabetes	___ Liver disorder	___ Rheumatic fever
___ Blood disorder	___ Encephalitis	___ Lung Disorder	___ Scarlet fever
___ Brain disorder	___ Enzyme deficiency	___ Measles	___ Tuberculosis
___ Broken bones	___ Genetic disorder	___ Meningitis	___ Venereal disease
___ Cancer	___ Heart disorder	___ Metabolic disorder	___ Whooping cough
___ Eye problems	___ Tics (eye blinking, sniffing, and repetitive movement)		
___ Other problems			

57) As the child has been growing up, he/she has been sick:

Much of the time \_\_\_ An average amount \_\_\_ Not much at all \_\_\_

58) List all the medications the child takes now:

Medication	Dosage	How often?	What for?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

59) Does the child?

Wear glasses? Yes \_\_\_ No \_\_\_ (Farsighted \_\_\_ Nearsighted \_\_\_ Other \_\_\_)  
Use a hearing aid? Yes \_\_\_ No \_\_\_

60) Within the past year has the child had:

A vision test? Yes \_\_\_ No \_\_\_  
A hearing test? Yes \_\_\_ No \_\_\_

**RESULTS**

\_\_\_\_\_  
\_\_\_\_\_

61) What is the child's: Height: \_\_\_ ft. \_\_\_ in.

Weight: \_\_\_ lbs.

62) When was the child's last medical checkup? \_\_\_\_\_

63) What therapies have been provided to the child?

\_\_\_ No therapies

- \_\_\_ Occupational therapy
- \_\_\_ Physical therapy
- \_\_\_ Psychological therapy, counseling, or cognitive rehabilitation
- \_\_\_ Speech therapy
- \_\_\_ Other therapy \_\_\_\_\_

**FAMILY HISTORY**

64) The child lives with:

- \_\_\_ Biological parent(s) only
- \_\_\_ Biological parent and other
- \_\_\_ Other placement \_\_\_\_\_
- \_\_\_ Relatives
- \_\_\_ Adoptive parents
- \_\_\_ Foster parents
- \_\_\_ Institutional care

Please list all the people currently living in the home with the child and their relation to the child (include family and nonfamily members) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

65) The family's income is:

under \$10,000 \_\_\_ \$10,000-29,999 \_\_\_ \$30,000-50,000 \_\_\_ over \$50,000 \_\_\_

66) What is the name of the child's biological mother? \_\_\_\_\_

a. Is she living? Yes \_\_\_ No \_\_\_ If deceased, explain: \_\_\_\_\_

b. Her age? \_\_\_\_\_

c. What is her level of education? \_\_\_\_\_

d. Her occupation? \_\_\_\_\_

If mother works outside the home, how many hours and what days \_\_\_\_\_

e. Does she live in the same house as the child? Yes \_\_\_ No \_\_\_

f. How often does she see the child? \_\_\_\_\_

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

h. During school, did the mother have:

Learning problems \_\_\_\_\_

Attention problems \_\_\_\_\_

Behavior problems \_\_\_\_\_

Medical problems \_\_\_\_\_

i. What are the mother's hobbies? \_\_\_\_\_  
\_\_\_\_\_

j. What is mother's primary language \_\_\_\_\_ Secondary language \_\_\_\_\_

- 67) What is the name of the child's biological father? \_\_\_\_\_
- a. Is he living? Yes \_\_\_ No \_\_\_ If deceased, explain: \_\_\_\_\_
  - b. His age? \_\_\_\_\_
  - c. What is his level of education? \_\_\_\_\_
  - d. His occupation? \_\_\_\_\_  
If father works outside the home, how many hours and what days \_\_\_\_\_
  - e. Does he live in the same house as the child? Yes \_\_\_ No \_\_\_
  - f. How often does he see the child? \_\_\_\_\_
  - g. How involved is the father in the child's upbringing? Very \_\_\_ Somewhat \_\_\_ Not at all \_\_\_
  - h. During school, did the father have:  
Learning problems \_\_\_\_\_  
Attention problems \_\_\_\_\_  
Behavior problems \_\_\_\_\_  
Medical problems \_\_\_\_\_
  - i. What are the father's hobbies? \_\_\_\_\_
  - j. What is father's primary language \_\_\_\_\_ Secondary language \_\_\_\_\_

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

Name	Age	Grade or job	Medical, Social, School Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

69) Has anyone in the child's biological family (including parents, grandparents, siblings, aunts, and uncles) ever had any of the following?

	Which relative?	Describe the problem briefly
___ Brain disease	_____	_____
___ Developmental Delay	_____	_____
___ Epilepsy or seizures	_____	_____
___ Learning disability	_____	_____
___ Mental retardation	_____	_____
___ Neurologic disease	_____	_____
___ Psychological problems	_____	_____
___ Reading/spelling difficulties	_____	_____
___ Speech/language problems	_____	_____

70) Which of the child's biological relatives are left-handed? No one \_\_\_\_\_  
Mother \_\_\_ Father \_\_\_ Sibling(s) \_\_\_ Grandparents \_\_\_

71) What languages are spoken in the home? (List in order of most frequent first)  
(1) \_\_\_\_\_ (2) \_\_\_\_\_

72) How is the child disciplined? \_\_\_\_\_

Is the discipline effective? \_\_\_\_\_



73) List the child's usual recreational activities and hobbies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

74) 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

75) Does the child attend day care outside the home or does someone come into the home to provide the service? \_\_\_\_\_  
Does day care provide any type of formal program of play, developmental, or academic activities? \_\_\_\_\_  
\_\_\_\_\_

**PEER RELATIOHSIPS**

76) Does your child seek friendships with peers? \_\_\_\_\_  
\_\_\_\_\_  
77) Is your child sought by peers for friendship? \_\_\_\_\_  
\_\_\_\_\_  
78) Does your child play with children primarily his or her own age ? \_\_\_\_\_  
Younger? \_\_\_\_\_ Older? \_\_\_\_\_  
79) Describe any problems your child may have with peers \_\_\_\_\_  
\_\_\_\_\_

**SCHOOL HISTORY**

80) The child's present school is: Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_ Contact person \_\_\_\_\_

81) Was the child ever held back to repeat a grade? Yes \_\_\_ No \_\_\_  
If yes, which grade? \_\_\_\_\_ Why? \_\_\_\_\_  
\_\_\_\_\_

82) Has the child ever been in a special class or provided with special services (e.g., RSP, Self-contained day class, learning or language disability class, etc.) Yes \_\_\_ No \_\_\_  
If yes, describe the special class \_\_\_\_\_  
\_\_\_\_\_

Is the child in this class or receiving special services now? Yes \_\_\_ No \_\_\_  
If yes, describe the present class placement \_\_\_\_\_  
\_\_\_\_\_

83) Does the child like school? Most of the time \_\_\_ Sometimes \_\_\_ Almost never \_\_\_

84) 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 \_\_\_

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

\_\_\_\_\_

86) 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 \_\_\_

Or

Other grading system \_\_\_\_\_

Are these grades a change from previous years? Yes \_\_\_ No \_\_\_

If yes, describe \_\_\_\_\_

87) In which subject(s) does the child do best? \_\_\_\_\_

88) Which subject(s) are the most difficult? \_\_\_\_\_

89) In the past year, how much school has the child missed due to illness or injury?

Less than 2 weeks \_\_\_ 2-4 weeks \_\_\_ 5-8 weeks \_\_\_ Over 8 weeks \_\_\_

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

\_\_\_\_\_

90) Does the child seem to have a "school phobia?" Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

91) Do you consider your child to understand directions and situations as well as other children his or her age? \_\_\_\_\_

92) How would you rate your child's overall intelligence compared to other children?

Below average \_\_\_ Above average \_\_\_ Average \_\_\_

**PREVIOUS EVALUATIONS**

93) Which of these tests or procedures has recently has been done? Note if normal or abnormal

Evaluation	Normal	Abnormal	Date
___ Blood work	_____	_____	_____
___ Family physician or pediatrician office visit	_____	_____	_____

<input type="checkbox"/> Hearing testing	_____	_____	_____
<input type="checkbox"/> Lead level check	_____	_____	_____
<input type="checkbox"/> Lumbar puncture or spinal tap	_____	_____	_____
<input type="checkbox"/> Neurological examination or testing (CT scan, EEG)	_____	_____	_____
<input type="checkbox"/> Psychological or Neuropsychological testing	_____	_____	_____
<input type="checkbox"/> School testing	_____	_____	_____
<input type="checkbox"/> Speech & Language testing	_____	_____	_____
<input type="checkbox"/> Vision testing	_____	_____	_____
<input type="checkbox"/> X-rays	_____	_____	_____
<input type="checkbox"/> Other tests:	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

94) What are the names of the physician, psychologist, school authority, or other professionals who are most familiar with the child's problems?

Name _____	Name _____
Address _____	Address _____
_____	_____
Phone _____	Phone _____
Profession _____	Profession _____

**Please Note: If your child has seen a psychologist at any time in the last year for testing or treatment, please be sure to advise the doctor.**

**ADDITIONAL COMMENTS:** Please note below any further information you feel may be helpful in the evaluation of your child

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent or Guardian's Signature Date

**THANK YOU FOR TAKING THE TIME TO CAREFULLY COMPLETE THIS QUESTIONNAIRE.**