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All information is confidential. We understand it may be difficult to answer some of the questions asked. Please answer to the best of your ability.

CHILD'S NAME: _____ DATE: _____

DATE OF BIRTH: _____

GENDER: ☐ Male ☐ Female

ETHNICITY: _____

HANDEDNESS: ☐ Right ☐ Left ☐ Ambidextrous

EDUCATION: _____ grade

This form was completed in whole, or in part, by:

_____

Relationship to child:

_____

With whom does the child reside? Please circle one:

Natural Parents One Parent Alone Parent & Step-Parent Foster/Adoptive Parents

Legal Guardian Other (specify): _____

Parents are (Circle one): Married Separated Divorced Widowed Unmarried

Mother's Information:

Name: _____ Date of Birth: _____

Address (if other than child's):

_____

City: _____ State: _____ Zip: _____
Occupation: _____
Highest grade completed in school: _____
Work Phone: _____
Home Phone: _____

Father's Information:

Name: _____ Date of Birth: _____

Address (if other than child's):

_____

City: _____ State: _____ Zip: _____
Occupation: _____
Highest grade completed in school: _____
Work Phone: _____
Home Phone: _____

Step-Parent's Information (If applicable):

Name: _____ Date of Birth: _____
Age of child when step-parent entered family: _____
Occupation: _____
Highest grade completed in school: _____
Work Phone: _____
Home Phone: _____

Legal Guardian's Information (If different than biological parent(s) or step-parent(s)):

Name: _____ Date of Birth: _____
Address (if other than child's):

_____

City: _____ State: _____ Zip: _____
Occupation: _____
Highest grade completed in school: _____
Work Phone: _____
Home Phone: _____

I. REFERRAL INFORMATION

Who referred you for the neuropsychological evaluation?

_____

What are the specific concerns you would like addressed in our assessment and interpretive sessions with you? (Please circle all that apply.)

Educational Getting along with others Social/Emotional

Medical/Neurological Behavior Activity Level Speech Development

Intellectual Motor Skills Language Development

Other (Please explain) _____

Any other concerns?

_____

_____

_____

II. FAMILY / SOCIAL HISTORY

1. Recent Family Stress?

☐ None
☐ Separation/Divorce
☐ Unemployment/Financial Problems
☐ Relocation
☐ Death of a Family Member
☐ Other (please explain): _____

_____

2. Family History:

Please place a check mark besides any positive history. Also, provide which family member (parents, siblings, aunts, uncles, grandparents, cousins)

☐ Learning Problems _____

☐ Attention-Deficit/Hyperactivity Disorder _____

☐ ADD / ADHD _____

☐ Intellectual Disability (Mental Retardation) _____

☐ Autism Spectrum Disorders _____

☐ Epilepsy/Seizure Disorder _____

☐ Other Neurologic Problems (Multiple Sclerosis, Parkinson's Disease, Tourette Syndrome)

_____

☐ Bipolar Disorder _____

☐ Schizophrenia _____

☐ Depression/Anxiety _____

☐ Endocrine Issues (Diabetes, Hypo- or Hyperthyroid, growth issues) _____

☐ Alcohol/Drug Abuse _____

☐ Other (Please Explain):

_____

_____

_____

III. PREGNANCY AND BIRTH HISTORY

1. Birth Weight: _____ lbs. _____ oz.

2. Mother's age at the time of pregnancy: _____

   Father's age at the time of pregnancy: _____

3. Number of pregnancies of child's natural mother: _____

Number of live births of child's natural mother: _____

4. Prenatal care began: ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester ☐ No prenatal care

5. Any of the following problems occur during pregnancy? If so, check boxes below

☐ Bleeding/Spotting
☐ Injuries
☐ Diabetic state in pregnancy (sugar in urine)
☐ High blood pressure
☐ Infections
☐ Toxic Exposure
☐ Preterm Labor

Maternal weight gain: _____ lbs

Fetal Activity: _____ Normal _____ Increased _____ Decreased

Prescribed Medications during Pregnancy:

_____

_____

Other Problems: _____

_____

6. During your pregnancy did the child's mother use any of the following? Please check boxes that apply.

☐ Alcohol
☐ Tobacco
☐ Drugs, If yes, what substances? _____

7. Length of Pregnancy: _____ weeks

8. Labor: ☐ Spontaneous ☐ Induced How long was labor (in hours)? _____

9. Delivery: ☐ Vaginal, if vaginal, was delivery assisted by: ☐ Vaccuum ☐ Forceps

☐ Cesarean, if C-section, was it: ☐ Planned ☐ Emergency

If emergency C-section, why was it completed? _____

_____

10. Did newborn require oxygen, resuscitation, or reviving after birth? ☐ Yes ☐ No

What were the baby's Apgar scores (if known)? 1 minute_____ 5 minute_____

11. Did the baby stay in intensive care or the regular nursery? ☐ Yes ☐ No

If placed in intensive care, for how long?_____

12. Place of birth: _____ Name of Hospital: _____

13. Discharge from hospital at _____ days of life

Any of the following problems in the nursery? If so, check the ones that apply

☐ Breathing problems
☐ Infections
☐ High or low blood sugar
☐ Seizures
☐ High or low temperature
☐ Feeding Problems
☐ Jaundice (yellow skin)
☐ Heart Problems
☐ Stroke/Hemorrhage
☐ Other: _____

IV. DEVELOPMENTAL HISTORY

Was your child breast fed? ☐ Yes ☐ No

Any issues with early feeding (poor latching, poor such reflex, reflux)? ☐ Yes ☐ No

Any concerns with baby's behavior (excessive crying, poor sleeping, colic)? ☐ Yes ☐ No

If yes, what specifically?_____

Developmental Speech/Language Milestones: ☐ Early ☐ Typical ☐ Late

Age when spoke?		
	First words	_____ months
	Two-word Combinations	_____ months
	Full sentences/phrases	_____ months

Developmental Motor Milestones: ☐ Early ☐ Typical ☐ Late

Age when?		
	Crawled	_____ months
	Stood without support	_____ months
	Walked	_____ months

Did your child ever receive? ☐ Physical therapy, if yes, age when started ? _____
☐ Occupational Therapy, if yes, age when started? _____
☐ Speech and Language Therapy, if yes, age when started? _____

Delays in toileting? ☐ Yes ☐ No if yes, age child was dry through the night? _____

History of recurrent ear infections? ☐ Yes ☐ No

if yes, were ear tubes placed and if so at what ages?

_____

V. HEALTH HISTORY (PAST MEDICAL HISTORY)

Who is your child's primary care doctor? _____

Any medical problems aside from referring concern? ☐ Yes ☐ No

If yes, age child was dry through the night?

_____

_____

_____

Any surgical history? ☐ Yes ☐ No

If yes, provide type of surgery and age surgery occurred._____

_____

_____

Any history of head injury with loss of consciousness or skull fracture? ☐ Yes ☐ No

If yes, provide age at time of injury and details regarding the injury._____

_____

Current medications?_____

_____

Does your child have any allergies to foods or medications? ☐ Yes ☐ No

If yes, please explain: _____

_____

Are your child's immunizations (shots) current and up to date? ☐ Yes ☐ No

Any history of contracting an early childhood disease (measles, mumps, etc)? ☐ Yes ☐ No

If yes, specify type of disease and age of illness:_____

_____

VI. REVIEW OF SYSTEMS

Please check if your child has experienced any of the following:

Vision and tactile perception:

☐ Wears glasses or contacts for vision correction
☐ Numbness/Loss of Sensation
☐ Blurred or Double Vision
☐ Tingling/Burning
☐ Loss of Vision/Blind Spots
☐ Poor pain or temperature sensitivity

Previous vision screen/ophthalmologic assessment? ☐ Yes ☐ No

If yes, when and what were results? _____

Hearing, taste & smell:

☐ Wears hearing aid? If yes, used in: ☐ Right Ear ☐ Left Ear ☐ Worn Bilaterally
☐ Change in Taste
☐ Loss of Hearing
☐ Ringing
☐ Change in Smell

Previous hearing screen/audiologic assessment? ☐ Yes ☐ No

If yes, when did it occur and what were results? _____

Sleep:

When is bedtime on a school night? _____ Weekend night? _____

Problems with sleep onset during school week? ☐ Yes ☐ No

Does he or she sleep in their own bed throughout the night? ☐ Yes ☐ No

What time does he or she wake on school day? _____ Weekend day? _____

Any sleep apnea concerns? ☐ Yes ☐ No

Any other sleep difficulties (Frequent nightmares, night terrors, sleep walking)?
☐ Yes ☐ No

What specifically and how frequently? _____

Appetite:

- ☐ Light appetite
- ☐ Large appetite
- ☐ Recent weight loss
- ☐ Recent weight gain
- ☐ Limited variety of foods he or she will eat
- ☐ Texture issues with food

Pain:

- ☐ None
- ☐ Head
- ☐ Back
- ☐ Chest
- ☐ Abdominal
- ☐ Pain when urinating

Attention/Concentration:

- ☐ Fails to pay attention to details or makes careless mistakes in schoolwork or other activities
- ☐ Often has trouble holding attention on tasks or play activities
- ☐ Often does not seem to listen when spoken to directly
- ☐ Often does not follow through on instructions and fails to finish schoolwork, chores, etc
- ☐ Often has trouble organizing tasks and activities
- ☐ Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period
- ☐ Often loses things necessary for tasks and activities such as school materials, keys, etc.
- ☐ Is often easily distracted
- ☐ Is often forgetful in daily activities

Hyperactivity/Impulsivity:

- ☐ Often fidgets with or taps hands or feet, or squirms in seat
- ☐ Often leaves seat in situations when remaining seated is expected
- ☐ Often runs about or climbs in situations where it is not appropriate
- ☐ Is frequently restless, acts as if "on the go" or acts as if "driven by a motor"
- ☐ Often unable to play or take part in leisure activities quietly
- ☐ Often talks excessively
- ☐ Often blurts out an answer before a question has been completed
- ☐ Often has trouble waiting his or her turn
- ☐ Often interrupts or intrudes on others

Motor:

- ☐ Decreased Coordination
- ☐ Motor / Vocal Tics
- ☐ Motor Weakness
- ☐ Fainting or Blackout Spells
- ☐ Spasms/Tremors
- ☐ Dizziness While Sitting
- ☐ Dizziness Upon Standing
- ☐ Any problems with range of movement or flexibility
- ☐ Any staring episodes where you cannot get your child's attention by touching arm, calling name, etc?

Memory:

- ☐ Problems with short-term recall
- ☐ Poor memory for faces
- ☐ Poor memory for names
- ☐ Difficulty remembering past experiences
- ☐ Difficulty with retrieving information when asked open ended questions
- ☐ Poor verbal memory
- ☐ Poor visual memory
- ☐ Problems remembering previously learned math concepts
- ☐ Problems remembering spelling words
- ☐ Problems following directions with multiple steps (directions involving 3 or more steps)

Speech and Language:

- ☐ Difficulty Expressing Thoughts
- ☐ Difficulty Understanding Others
- ☐ Problems with speech articulation or speech clarity
- ☐ Experiences difficulty finding words or seems to have frequent hesitations when talking
- ☐ Problems with correctly naming objects
- ☐ Stutters
- ☐ Frequently asks for repetition of instructions
- ☐ Does not engage in frequent conversation

Visual-spatial processing:

- ☐ Trouble with visual tasks (e.g., puzzles, games, etc.)
- ☐ Has poor handwriting
- ☐ Reversals of letters or numbers
- ☐ Right-left confusion
- ☐ Writing is poorly spaced, smashed together, or drifts up or down when writing
- ☐ Often bumps into walls, objects, or people
- ☐ Has poor interpersonal space (i.e., stands too close to people or too far away)

Executive functions:

☐ Poor organization (often loses homework assignments, frequently misplaces objects)
☐ Poor planning
☐ Poor judgement and decision making
☐ Often acts without thinking
☐ Problems with initiating tasks independently
☐ Difficulty following multistep directions
☐ Problems with behavior and/or emotional regulation
☐ Room, backpack, locker, etc. is often very messy or poorly organized

VII. SCHOOL INFORMATION

1.) Has your child received Early Intervention Services? ☐ Yes ☐ No

How old was child at time that services started? _____

What therapies were provided? ☐ Speech/Language ☐ Occupational ☐ Physical

2.) Schools attended

Preschool / Kindergarten: _____

Elementary School: _____

Middle School / Jr High: _____

High School: _____

3.) Previous psychoeducational testing completed by school district? ☐ Yes ☐ No

(IF YES, PLEASE REQUEST A COPY OF THE TEST RESULTS TO ATTACH WITH THE QUESTIONNAIRE.)

4.) Is there a current Individualized Education Program (IEP) in place? ☐ Yes ☐ No

(IF YES, PLEASE ENCLOSE A COPY WITH THE QUESTIONNAIRE.)

5.) What therapies are currently provided?

☐ None ☐ Speech/Language ☐ Occupational ☐ Physical ☐ Social Skills

6.) What are your child's current grades? ☐ Above Average ☐ Average ☐ Below Average

7.) Has there been a recent change in your child's grades? ☐ Yes ☐ No

8.) Has your child repeated any grades? ☐ Yes ☐ No

If yes, what grade or grades? _____

9.) What are your child's favorite subjects?

_____

_____

VIII. SOCIAL / EMOTIONAL DEVELOPMENT:

Has your child been previously diagnosed with a psychiatric condition such as depression, anxiety, ADHD, autism spectrum disorder, etc? ☐ Yes ☐ No

If so, what condition and who diagnosed your child with the condition? _____

_____

Has your child had counseling or therapy in the past? ☐ Yes ☐ No

Is your child receiving therapy now? ☐ Yes ☐ No

If yes, with whom and for how long? _____

_____

57. Please circle the traits/characteristics below which apply to your child now:

Happy	Sad	Moody
Friendly	Quiet	Overactive
Independent	Dependent	Imaginative
Sensitive	Affectionate	Fearful
Lethargic	Requires a lot of parental attention	Responsible
Even tempered	Short attention span	Impulsive
Angry	Lacking in self-control	Explosive
Good sense of humor	Withholding of affection	Thoughtful
Dreamer	Difficulty calming down	Cooperative
Withdrawn	Easily over-stimulated	Curious

Please check any current behavioral concerns or issues

- ☐ Cries frequently
- ☐ Excessive sadness
- ☐ Verbally aggressive
- ☐ Physically aggressive
- ☐ Withdrawn from activities that he or she previously enjoyed
- ☐ Has frequent mood swings
- ☐ Is often angry or irritable
- ☐ Has experienced panic attacks
- ☐ Frequently gets in fights
- ☐ Has difficulty relating to other children
- ☐ Prefers to play with younger children
- ☐ Argues frequently with friends and/or family members
- ☐ Has difficulty making friends
- ☐ Has difficulty keeping friends
- ☐ Prefers to play by his or her self rather playing with others
- ☐ Seems to have difficulty understanding nonverbal cues such as understanding sarcasm
- ☐ Has trouble getting along with siblings more so that typical sibling rivalry issues
- ☐ Expresses suicidal ideation or thoughts of hurting self or others
- ☐ Has attempted suicide in the past
- ☐ Has experienced visual hallucinations
- ☐ Has experienced auditory hallucinations
- ☐ Has a history of inpatient psychiatric hospitalization
- ☐ Engages in excessive eating to the point of vomiting
- ☐ Is very sensitive to the amount of food eaten or seems excessive focused on quantity of food eaten

Additional Comments:

_____

_____

_____

Parent/Guardian Signature: _____

Relationship to Child: _____

Date: _____

Directions: This form should be completed by the child's natural mother or other individual having intimate knowledge of this pregnancy and birth. For each of the following questions or statements, choose the response which best answers it for the child named above. Indicate your response by writing the number for that statement in the space to the left.

1. _____Just before this pregnancy, the mother's weight was approximately:

    1. less than 90 lbs
    2. 91-110
    3. 111-120
    4. 121-130
    5. 131-140
    6. 141-150
    7. greater than 151

2. ____ The mother's height at the time of pregnancy was:

    1. less than 5 ft.
    2. 5 ft., 1 in. – 5 ft., 3 in.
    3. 5 ft., 4 in. – 5 ft., 5 in.
    4. 5 ft., 6 in.—5 ft., 8 in
    5. 5 ft., 9 in., -- 5 ft., 11 in.
    6. 6 ft or greater

3. _____The father's height is:

    1. less than 5 ft.
    2. 5 ft., 1 in – 5 ft., 3 in
    3. 5 ft., 4 in. – 5 ft,. 5 in
    4. 5 ft., 6 in. – 5 ft., 8 in
    5. 5 ft., 9 in. – 5 ft., 11 in
    6. 6ft. – 6 ft., 1 in
    7. 6 ft., 2 in or greater

4. _____The number of pregnancies prior to the birth of the child names above was

    1. none
    2. one
    3. two
    4. three or more

5. _____What was the amount of vaginal bleeding during pregnancy?

    1. none
    2. some near the end of pregnancy
    3. some at the beginning of pregnancy
    4. a good deal throughout

6. _____What type of anesthesia was employed during the delivery?

    1. saddle block (anesthesia injected into the spine)
    2. inhaled general anesthesia (eg., "gas," ether)
    3. injected general anesthesia
    4. none

7. _____The child's weight at birth was:

    1. less than 3 lbs
    2. 3 lbs., 1 oz to 4 lbs.
    3. 4 lbs., 1 oz. to 5 lbs.
    4. 5 lbs., 1 oz. to 6 lbs
    5. more than 6 lbs.

8. _____ What was the amount of stress the mother experienced during the pregnancy?

    1. very little
    2. a moderate amount
    3. a good deal throughout

9._____The child was born after how many months of pregnancy?

1. 6
2. 7
3. 8
4. 9
5. greater than 9 months
6. not sure

9. _____ Approximately what was the length of labor (with regular contractions) prior to birth?

1. 1-2 hours
2. 3-5 hours
3. 6-10 hours
4. 11-16 hours
5. more than 16 hours

11. _____About how much weight was gained by the mother during pregnancy?

1. less than 10 lbs
2. 11-15 lbs.
3. 16-25 lbs
4. 26-35 lbs
5. 36-45 lbs
6. in excess of 46 pounds.

12. _____ Mother's age at time of this child's birth was:

1. under 15 years
2. 15-19 years
3. 20-29 years
4. 30-34 years
5. 35-39 years
6. over 40 years

13. _____ During the pregnancy when did the mother first consult a physician?

1. months 1-3
2. months 4-6
3. months 7-8
4. after 8th month

14. _____ To what extent did the mother experience swelling of legs, feet or hands during pregnancy?

1. minimal
2. some near the end of pregnancy
3. some near the beginning of pregnancy
4. a good deal throughout

15. _____ Was labor medical induced for this child?

1. no
2. yes – prior to month nine
3. yes – after month nine

16._____ Were forceps necessary in the delivery of this child?

1. no forceps were necessary
2. yes, forceps were used (check one: high forceps, low forceps, not sure)
3. birth was cesarean
4. not sure

17. _____ The degree to which this pregnancy was planned for was:

1. carefully planned for
2. not planned but pleased
3. not planned but happy with the news
4. unplanned and unmarried at the time of pregnancy

18. ____ Was the pregnancy for this child a multiple pregnancy?

1. yes-twins
2. yes – triplets or more
3. no

19. _____ What medication was taken by the mother during this pregnancy?

1. prescribed vitamins and/or iron
2. drugs to reduce tension
3. water loss medication
4. aspirin on at least a weekly basis
5. other _____
6. no medication was taken

20. ____ What was the direction of this child at the time of delivery?

1. feet first presentation (breach birth)
2. head first presentation
3. side presentation
4. not sure but have no reason to believe it was different from most other births

21_____ The amount of time which passed from membrane rupture (breaking of water) to the start of labor for this child was:

1. medication was necessary to induce labor
2. contractions began prior or at the time of membrane rupture (breaking of water)
3. labor began naturally after less than two hours
4. labor began naturally after more than two hours
5. not sure

22. _____ Soon after birth was there a time when your child's color was blue?

1. yes
2. no
3. did not see it, but this was reported to me

23._____What was the extent of gynecological surgery necessary prior to the birth of this child (more than one number may be indicated)?

1. surgery was necessary to correct infertility
2. surgery was necessary during pregnancy
3. prior to therapeutic abortion
4. prior to voluntary abortion
5. surgery was necessary more than two years prior to this pregnancy
6. episiotomy (incision of vaginal opening to facilitate delivery) for prior birth
7. no prior gynecological surgery

24._____ The number of pregnancies prior to the birth of this child was:

1. none
2. one or more full term resulting in a stillbirth of neonatal (first four weeks after birth) death
3. one of more resulting in normal birth
4. one or more resulting in spontaneous abortion (miscarriage)

25. _____The average number of cigarettes smoked per day during pregnancy was:

1. none
2. 1-10
3. 11-20
4. 21-30
5. more than 30

26. _____ The average amount of alcohol consumed per day during pregnancy was:

1. none
2. 1 to 2 drinks
3. 3 to 4 drinks
4 more than 5 drinks

Place a check mark next to each condition which occurred in the mother just prior to or during pregnancy of this child:

27. _____ thyroid disease
28. _____ high blood pressure
29. _____ anemia (weakness and paleness due to a deficiency of blood)
30. _____ neurological problem
31. _____ emotional problem
32. _____ urinary tract infection
33. _____ gonorrhea
34. _____ syphilis
35. _____ heart disease
36. _____ sickle-cell trait (hereditary abnormality of red blood cells)
37. _____ diabetes
38. _____ mother-baby blood differences (Rh negative, sensitized)
39. _____ viral infection
40. _____ high temperatures
41. _____ fainting spells
42. _____ parasitic infections
43. _____ narcotic use (e.g., heroin, morphine, codeine)
44. _____ physical trauma
45. _____ malnutrition
46. _____ depression
47. _____ tranquilizer use