Child and Adolescent History Form

Neuropsychology

Child Information and Reason for Referral

Child's Name________________________________ Date of Birth ___________________

Race/Ethnicity ____________________________

Name of person completing this form___________________________________

Relationship to child: ____

Address: ____

____

Home Phone (___) - ___________________ Work Phone (___) - ________ -

Custody of child:

- ❑ Married, both parents
- ❑ Joint legal custody
- ❑ Joint physical custody
- ❑ Sole custody
- ❑ Third-party custody (specify) _______

Please provide the name, address, and phone number of any other person sharing custody of the child.

Address:____

____

Home Phone (___) - ___________________ Work Phone (___) - ________ -

Person and organization that referred you for evaluation:

____

Reason for evaluation: ____

____

____

____

When did you or others first become concerned? ____

____

____

My greatest concern for my child is:
____

The most important question I have is:

In my opinion, the major cause of my child's problem is: ____________________

My child's greatest abilities are: ____________________

My child's greatest limitations are: ____________________

The person in the family that my child most takes after is: ____________________

Do both parents agree about the nature of the problems? ____________________

How much discomfort are the current problems causing for the **child**?

0 **Not at All.** Very comfortable, no difficulty from current complaints	2 Little discomfort	4 Mild discomfort	6 Moderate discomfort	8 Severe discomfort	10 **Very Severe** discomfort

Please rate how much do the current problems interfere with:	Not at All					Very Sever e
Communication	0	1	2	3	4	5
Family routines	0	1	2	3	4	5
Getting along with family members	0	1	2	3	4	5
Getting along with peers	0	1	2	3	4	5
Getting along with teachers	0	1	2	3	4	5
Getting to and staying at school/daycare/work	0	1	2	3	4	5
Helping with chores	0	1	2	3	4	5
School work/homework	0	1	2	3	4	5
Self-care	0	1	2	3	4	5
Health	0	1	2	3	4	5

Medical History

Child's Primary Care Provider: ___________________________

Please list **current** medications, dose, and reasons for medication:

Name of medication and dose	Reason(s)

Has your child ever seen any of the following medical professionals?

Specialist	Name	Ages	Diagnosis
Neurologist			
Psychiatrist			
Psychologist			
Ophthalmologist			
Ear, Nose and Throat (ENT; Otolaryngologist)			
Audiologist			
Geneticist			
Physiatrist			
Orthopedist			
Oncologist			
Social Worker or Therapist			
Speech Therapist			
Occupational Therapist			
Physical Therapist			
Other			

Has your child been **suspected of** having **been <u>diagnosed</u> by a <u>medical professional</u>** with any of the following conditions?

	Suspected	Diagnosed	Date	Name of Provider
Anoxia/Hypoxia				
Stroke				
Encephalitis/Meningitis				
Autism Spectrum Disorder (including Asperger Disorder)				
Poisoning (lead, mercury)				
Alcohol or Substance Abuse				
ADHD				
Learning Disability, Dyslexia				
Depression				
Anxiety				
Neurological Disorders				
Brain tumor (in remission/with slow progression)				
Cerebral palsy or static encephalopathy				
Epilepsy Age at first seizure: Date of last seizure::				
Hydrocephalus ❑ Without shunt ❑ With shunt				
Receptive or Expressive Language Disorder				
Multiple Sclerosis				
Genetic Condition Specify (e.g., Fragile X, PKU)				
Structural Brain Abnormality (from MRI)				
Cognitive impairment, intellectual disability, mental retardation, or global developmental delay				

Please list any other serious illnesses, injuries, hospitalizations, and surgeries:

Event and Reason	Age

Pregnancy, Labor, and Delivery

Is your child: ❑ Biological ❑Adopted ❑Foster

How long was the pregnancy? (in weeks) _______weeks

Was the pregnancy planned ? ❑ Yes ❑ No

What medications did the mother take during pregnancy, and why? ______________
____

What complications were there during the pregnancy?

- ❑ None
- ❑ Bleeding
- ❑ High blood pressure (e.g., toxemia)
- ❑ Infections
- ❑ Seizures (mother)
- ❑ Injury or accident
- ❑ Hospitalization
- ❑ German Measles, Rubella
- ❑ Placenta abruptia
- ❑ Placenta previa
- ❑ Polyhydramnios
- ❑ Oligohydramnios
- ❑ Rh Incompatibility
- ❑ Chronic Illness (e.g., diabetes, thyroid, mental health)
- ❑ Major life stress
- ❑ Other _________________________

Were ultrasounds performed ? _______________ Where results normal ? Yes No

How many cigarettes did the mother smoke during pregnancy? _________ per day

How much did the mother drink beer, wine, or other alcohol during the pregnancy? ______ drinks per week

Did the mother use any illegal substances during the pregnancy? If so, what kind and how much? ____

How long was labor (in hours)? _______hours

Please describe any complications with labor or delivery (e.g., breach position, cord wrapped around neck):

____

How was the baby delivered?

- ❑ Vaginal
- ❑ Vaginal, after a previous C-section
- ❑ C-Section
- ❑ Don't Know

How much did the baby weigh?__________Did the baby breathe spontaneously? _

How long was the baby in the hospital before going home (number of days)? ______days

Was the baby in intensive care, and if so, for how long? ______days

Did the baby require oxygen ? __________ Nasogastric tube ? ___________

Ventilation

Surfactant

Retinopathy of prematurity

What were the baby's APGAR scores? _____ at 1 min ______ at 5 min _______ at 10 min

Please describe any complications or medical procedures after the baby went home (e.g., jaundice, fever, transfusions)?

____

____

Please describe any problems in the first few months (Feeding, growth, vomiting, seizures, high fevers):

Developmental History

Sensory

Is there a history of any problems with Hearing (If your child has hearing aids, please bring them to the evaluation)

- ❑ No
- ❑ Temporary (conductive) hearing loss
- ❑ Permanent (sensorineural) hearing loss
- ❑ Other ______________________

Vision (If your child requires glasses or contact lenses, please bring them to the evaluation)

- ❑ No
- ❑ Requires glasses
- ❑ Legally blind
- ❑ Other ______________________

Motor

Does your child use primarily his or her:

❑ Right Hand ❑ Left hand ❑ Both hands

At what age did your child:

	Age		Age
Sit alone		Babble/coo	
Crawl		Say his or her first word	
Stand		Put 2-3 words together	
Walk alone		Sing the alphabet	
Ride a tricycle		Name three colors	
Skip and run		Name shapes	
Ride a bicycle		Count to 10	
Point a finger			
Turn pages in a book			
Hold a crayon and scribble			
Write his/her name			

Language

What languages are spoken at home? _________

Is English your child's primary language? _________

Social and Self-Help

Age when toilet trained:_________

Problems with bedwetting, soiling, or urine accidents?______________________________
______

Educational History

At what age did your child start Early On? Preschool? Daycare? Kindergarten? school?____________

Has your child had any special educational placements or services? __________
Has your child had any individual testing at school? ❑ No ❑ Yes (Dates)
____

Does your child have a special educational diagnosis, an Individual Educational Plan (IEP), or a 504 Plan? If so, please check the educational category below.

❑ Yes, but Don't Know
❑ 504 Plan
❑ Autism (AI)
❑ Cognitive Impairment (CI)
❑ Early Childhood Developmental Delay (ECDD)
❑ Emotional Impairment (EI)
❑ Language Disorder (SLI)
❑ Learning Disabled (SLD; specify)
❑ Multiple Disabilities
❑ Other Health Impairment (e.g., OHI, POHI)
❑ Sensory Impairment (SI)
❑ Traumatic Brain Injury (TBI)

Please list the schools attended, any testing, special services, discipline problems, and if your child repeated a grade.

Grade	Name of School(s)	Testing (✓)	Special Services (✓)	Repeated Grade (✓)	Grade point or letter grade average	Discipline Problems (✓)
Pre						
K						
1						
2						
3						
4						

Grade	Name of School(s)	Testing (✓)	Special Services (✓)	Repeated Grade (✓)	Grade point or letter grade average	Discipline Problems (✓)
5						
6						
7						
8						
9						
10						
11						
12						

If your child has had any testing, please obtain a copy of the last **Diagnostic Summary or Evaluation Summary** from the school.
If your child has been in special placement, please obtain a copy of the most recent **Individual Educational Plan** from the school.
If your child has had discipline problems, please obtain a copy of **discipline reports** from the school.

What educational services has your child received now or in the past?

	Grades Received
❑ Early childhood special education (e.g., Early On, 3 to 5 years of age)	
❑ Class within a class (e.g., tutoring, special aid)	
❑ Resource room (e.g., tutoring outside the classroom)	
❑ Self-contained special educational class	
❑ Behavior Intervention Plan	
❑ Physical therapy	
❑ Teacher consultant	
❑ Paraprofessional	
❑ Speech therapy	
❑ Occupational therapy	
❑ Social work	

At school, have there been any problems with:

	Grades Experienced

❑ Reading	
❑ Spelling	
❑ Arithmetic	
❑ Writing	
❑ Language Arts	

How would you describe your child's intelligence?

❑ Below average
❑ Average
❑ Above Average

What type of discipline has your child had at school ?

Action	Reason(s)
❑ Removed from the classroom	
❑ Tardiness	
❑ Demerits	
❑ Poor citizenship	
❑ Staying after school	
❑ Suspended	
❑ Expelled	
❑ Other________________________	

Family History

What is the marital status of the parents?

❑ Married ❑ Divorced ❑ Unmarried
❑ Separated ❑ Never Married ❑ Widowed

If custody is shared, please describe the living arrangement:___________________________

____

____

____

Please list all those with whom the child lives most of the time. Include yourself.

Name	Sex (M/F)	Age	Relationship to child (indicate step-, half- or full siblings)

Please list others who have major involvement in the care of your child (e.g., non-custodial parent, foster parents, stepparents, biological parents, grandparents, relatives, friends):

Name	Sex (M/F)	Age	Relationship to child

Please check any significant life events experienced by the child:

	Age of Child		Age of Child
❑ Change in living situation	________	❑ Conflict with school	________
❑ Change of schools	________	❑ Family economic problems	________
❑ Change of custody	________	❑ Family alcohol or drug abuse	________
❑ Marital conflict	________	❑ Family medical problems	________
❑ Parents Separated	________	❑ Family psychiatric illness	________
❑ Parents Divorced	________	❑ Physical or sexual abuse victim	________
❑ Post-Divorce conflict	________	❑ Death of family member	________
❑ Stepparent problems	________	❑ Death of pet	________
❑ Sibling birth	________	❑ Suicide in the family	________
❑ Disagreement over discipline	________		________
		Other ________________	________

Mother's History

Name ______________________________________

Age_________Education_________Occupation__________________________________

Father's History

Name ______________________________________

Age_________Education_________Occupation__________________________________

Please list all pregnancies in order, including the patient and any miscarriages Name	Sex (M/F)	Age of Mother	Complications

Please check if any family members have experienced these problems:	Mother	Father	Brother/ Sister	Mother's Relative	Father's Relative
ADHD					
Alcohol/Substance abuse					
Anxiety Disorder					
Asperger Disorder					
Autism					
Bipolar Disorder					
Birth Defects (e.g., congenital hearing loss, blindness, physical deformities)					
Brain tumor (in remission/with slow progression)					
Cerebral palsy or static encephalopathy					
Cognitive impairment, intellectual disability, mental retardation, or global					

Please check if any family members have experienced these problems:	Mother	Father	Brother/ Sister	Mother's Relative	Father's Relative
developmental delay					
Depression					
Diabetes					
Discipline or legal problems					
Encephalitis					
Epilepsy					
Genetic Condition (e.g., Fragile X, PKU)					
Heart problems					
High Blood Pressure					
Huntington's Chorea, Parkinson's Disease					
Hydrocephalus					
Kidney or liver disease					
Learning Disability, Dyslexia					
Legal Problems					
Multiple Sclerosis					
Poisoning (e.g., lead, mercury, other)					
Receptive or Expressive Language Disorder					
Stroke					
Structural Brain Abnormality (from MRI)					
Suicide					
Tics, Tourette Syndrome					
Other (specify)					

Additional Comments

Signature of person(s) completing this form

Relationship to child