**CHILD NEUROPSYCHOLOGICAL HISTORY QUESTIONNAIRE**

**CONFIDENTIAL**

**DEMOGRAPHIC INFORMATION**

Patient’s Name: Click or tap here to enter text.

Form Completed By: Click or tap here to enter text. Relationship to Child: Choose an item.

Child’s Date of Birth: Click or tap to enter a date. Current Age: Click or tap here to enter text.

Gender: Choose an item. Handedness: Choose an item.

Ethnicity: Click or tap here to enter text. Religion: Click or tap here to enter text.

Primary Language: Click or tap here to enter text. Additional Languages: Click or tap here to enter text.

Home Address: Click or tap here to enter text.

Home Phone: Click or tap here to enter text. Cell Phone: Click or tap here to enter text.

Current School: Click or tap here to enter text. Grade: Click or tap here to enter text.

Type of School:  Public  Private  Parochial  Other: Click or tap here to enter text.

**REFERRAL INFORMATION**

Person who referred for testing: Click or tap here to enter text.

Contact Information: Click or tap here to enter text.

What is your understanding of why this evaluation has been requested?

Click or tap here to enter text.

Has your child ever had neuropsychological testing before? Choose an item.

If yes, when? Click or tap here to enter text.

By whom? Choose an item.

Outcome? Choose an item.

**PROBLEM CHECKLIST**

Please check all problems your child has experienced AT ANY AGE, include age ranges, rate severity, and provide any additional details.

Severity ratings include: **1 = Mild; 2 = Mild to Moderate; 3 = Moderate; 4 = Moderate to Severe; 5 = Severe**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Problem Area** | **Ages** | | | | | **Severity** | **Additional Details** |
| **0-3** | **4-6** | **7-10** | **11-13** | **14-17** |
| **Physical/Motor:** |  |  |  |  |  |  |  |
| Headaches |  |  |  |  |  |  |  |
| Dizziness |  |  |  |  |  |  |  |
| Poor coordination |  |  |  |  |  |  |  |
| Poor balance |  |  |  |  |  |  |  |
| Visual problems |  |  |  |  |  |  |  |
| Hearing problems |  |  |  |  |  |  |  |
| Daytime sleepiness |  |  |  |  |  |  |  |
| Nighttime sleep difficulties |  |  |  |  |  |  |  |
| Sensitivity to noise |  |  |  |  |  |  |  |
| Sensitivity to light |  |  |  |  |  |  |  |
| Sensitivity to touch or textures |  |  |  |  |  |  |  |
| Odd movements (e.g. flapping) |  |  |  |  |  |  |  |
| Involuntary movements (e.g. tics) |  |  |  |  |  |  |  |
| Poor fine-motor skills |  |  |  |  |  |  |  |
| Other (specify) |  |  |  |  |  |  |  |
| **Language:** |  |  |  |  |  |  |  |
| Articulation |  |  |  |  |  |  |  |
| Fluency |  |  |  |  |  |  |  |
| Speak in monotone |  |  |  |  |  |  |  |
| Talks more than average |  |  |  |  |  |  |  |
| Talks about the same topic |  |  |  |  |  |  |  |
| Odd/unusual vocal sounds |  |  |  |  |  |  |  |
| Difficulty with conversations |  |  |  |  |  |  |  |
| Difficulty understanding language |  |  |  |  |  |  |  |
| Difficulty understanding directions |  |  |  |  |  |  |  |
| Other (specify) |  |  |  |  |  |  |  |

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| **Problem Area** | **Ages** | | | | | **Severity** | **Additional Details** |
|  | **0-3** | **4-6** | **7-10** | **11-13** | **14-17** |  |  |
| **Nonverbal Skills:** |  |  |  |  |  |  |  |
| Difficulty with puzzles, Legos, etc. |  |  |  |  |  |  |  |
| Confuses directions/orientation |  |  |  |  |  |  |  |
| Problems drawing or copying |  |  |  |  |  |  |  |
| Confuses colors (specify if color blind) |  |  |  |  |  |  |  |
| Difficulty recognizing objects |  |  |  |  |  |  |  |
| Difficulty recognizing known people |  |  |  |  |  |  |  |
| Difficulty dressing that is not physical |  |  |  |  |  |  |  |
| Other (specify) |  |  |  |  |  |  |  |
| **Problem-Solving Skills:** |  |  |  |  |  |  |  |
| Learning new activities/concepts |  |  |  |  |  |  |  |
| Organizing activities/belongings |  |  |  |  |  |  |  |
| Organizing schoolwork |  |  |  |  |  |  |  |
| Solving problems |  |  |  |  |  |  |  |
| Understanding explanations |  |  |  |  |  |  |  |
| Learning from errors |  |  |  |  |  |  |  |
| Varying play |  |  |  |  |  |  |  |
| Varying problem-solving strategies |  |  |  |  |  |  |  |
| Transitioning between activities |  |  |  |  |  |  |  |
| Completing activities on time |  |  |  |  |  |  |  |
| Understanding time limits |  |  |  |  |  |  |  |
| Quickly frustrated or gives up easily |  |  |  |  |  |  |  |
| Other (specify) |  |  |  |  |  |  |  |
| **School Skills:** |  |  |  |  |  |  |  |
| Learning to read letters/words |  |  |  |  |  |  |  |
| Reading comprehension |  |  |  |  |  |  |  |
| Writing letters |  |  |  |  |  |  |  |
| Writing sentences properly |  |  |  |  |  |  |  |
| Writing essays |  |  |  |  |  |  |  |
| Spelling |  |  |  |  |  |  |  |
| Math calculations |  |  |  |  |  |  |  |
| Math word problems |  |  |  |  |  |  |  |
| Completing schoolwork on time |  |  |  |  |  |  |  |
| Completing homework |  |  |  |  |  |  |  |
| Other (specify) |  |  |  |  |  |  |  |
| **Attention:** |  |  |  |  |  |  |  |
| Difficulty concentrating on schoolwork |  |  |  |  |  |  |  |
| Difficulty concentrating on play |  |  |  |  |  |  |  |
| Loses train of thought |  |  |  |  |  |  |  |
| Difficulty starting tasks |  |  |  |  |  |  |  |
| Other (specify) |  |  |  |  |  |  |  |

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| **Problem Area** | **Ages** | | | | | **Severity** | **Additional Details** |
|  | **0-3** | **4-6** | **7-10** | **11-13** | **14-17** |  |  |
| **Memory:** |  |  |  |  |  |  |  |
| Forgets where s/he leaves things |  |  |  |  |  |  |  |
| Forgets to bring home schoolwork |  |  |  |  |  |  |  |
| Forgets what happened recently |  |  |  |  |  |  |  |
| Forgets what happened last week |  |  |  |  |  |  |  |
| Remembers specific details |  |  |  |  |  |  |  |
| Remembers odd facts |  |  |  |  |  |  |  |
| Can recognize but not recall |  |  |  |  |  |  |  |
| Other (specify) |  |  |  |  |  |  |  |
| **Behavior & Emotions:** |  |  |  |  |  |  |  |
| Apathy or lack of interest |  |  |  |  |  |  |  |
| Sadness or depression |  |  |  |  |  |  |  |
| Loneliness |  |  |  |  |  |  |  |
| Loss of confidence |  |  |  |  |  |  |  |
| Feelings of guilts |  |  |  |  |  |  |  |
| Thoughts of death or suicide |  |  |  |  |  |  |  |
| Changes in appetite |  |  |  |  |  |  |  |
| Changes in sleep |  |  |  |  |  |  |  |
| Nightmares |  |  |  |  |  |  |  |
| Irritability |  |  |  |  |  |  |  |
| Restlessness |  |  |  |  |  |  |  |
| Personality changes |  |  |  |  |  |  |  |
| Temper outbursts |  |  |  |  |  |  |  |
| Mood swings or quick shifts |  |  |  |  |  |  |  |
| Crying spells |  |  |  |  |  |  |  |
| Excessive worry |  |  |  |  |  |  |  |
| Fears (specify) |  |  |  |  |  |  |  |
| Troubling thoughts |  |  |  |  |  |  |  |
| Repetitive behaviors or rituals |  |  |  |  |  |  |  |
| Immature for age |  |  |  |  |  |  |  |
| Overly dependent |  |  |  |  |  |  |  |
| Difficulty with peers |  |  |  |  |  |  |  |
| Increased suspicion of others |  |  |  |  |  |  |  |
| Hallucinations |  |  |  |  |  |  |  |
| Irrational beliefs |  |  |  |  |  |  |  |
| Self-stimulating behaviors |  |  |  |  |  |  |  |
| Self-injurious behaviors |  |  |  |  |  |  |  |
| Inappropriate sexual behavior |  |  |  |  |  |  |  |
| Risky behaviors |  |  |  |  |  |  |  |
| Use of alcohol or illegal drugs |  |  |  |  |  |  |  |

**DEVELOPMENTAL HISTORY**

**PREGNANCY AND BIRTH HISTORY:**

List all medications, drugs, alcohol used during pregnancy: Click or tap here to enter text.

Mother’s age at delivery: Click or tap here to enter text. Birth weight: Click or tap here to enter text.

Delivery was:  Vaginal  Planned cesarean  Emergency cesarean

Spontaneous  Induced

Easy  Moderately difficulty  Other: Click or tap here to enter text.

Baby was born:  Full term  Premature at Click or tap here to enter text. weeks gestation

Post-term at Click or tap here to enter text. weeks

Forceps used Vacuum extraction used

Were there any problems during the pregnancy or delivery? Choose an item.

If yes, describe: Click or tap here to enter text.

Was a gestational carrier, egg donor, or sperm donor used? Choose an item.

**INFANCY AND TODDLERHOOD:**

As a baby, appetite was: Choose an item. Describe: Click or tap here to enter text.

As a baby, sleep was: Choose an item.

Developmental milestones (mark early or late relative to the expected age range, and include age if known):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Skill area** | **Early** | **Average** | **Late** | **Compared to siblings, child was** |
| Crawled |  | 6-9 mos |  | Early  Same  Late |
| Walked alone (2-3 steps) |  | 9-18 mos |  | Early  Same  Late |
| First words |  | 12-15 mos |  | Early  Same  Late |
| Followed simple commands |  | 12-18 mos |  | Early  Same  Late |
| Used simple sentences |  | 18-30 mos |  | Early  Same  Late |
| Toilet trained |  | 2-3 yrs |  | Early  Same  Late |
| Can’t toilet independently due to physical symptoms | | | | |
| Overall Development |  |  |  | Early  Same  Late |

Describe any significant developmental problems: Click or tap here to enter text.

**MEDICAL HISTORY**

Check if your child has ever experienced the following and briefly describe (dates, frequency, treatment, etc):

Chronic ear infections Click or tap here to enter text.

Head injury (specify loss of consciousness) Click or tap here to enter text.

Seizures, convulsions, epilepsy Click or tap here to enter text.

Chronic headaches Click or tap here to enter text.

Neurological disorder Click or tap here to enter text.

Fainting spells Click or tap here to enter text.

Pneumonia Click or tap here to enter text.

Asthma Click or tap here to enter text.

Diabetes Click or tap here to enter text.

Irregular heart rhythm Click or tap here to enter text.

Cancer Click or tap here to enter text.

Infectious disease Click or tap here to enter text.

Genetic Disorder Click or tap here to enter text.

Other (specify) Click or tap here to enter text.

Please list all hospitalizations and surgeries that your child has experienced:

|  |  |
| --- | --- |
| **Age** | **Explanation** |
|  |  |
|  |  |
|  |  |

Overall, the child has been sick: Choose an item.

My child:  Wears glasses  Uses a hearing aide

Uses other aide (specify) Click or tap here to enter text.

Please list all current medications:

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Dosage** | **Date Started** | **Reason** |
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Please list any known allergies: Click or tap here to enter text.

**EDUCATIONAL HISTORY**

Please list all schools your child has attended:

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| --- | --- | --- | --- |
| **Dates / Ages** | **Name of School** | **Type of School** | **Class Size** |
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Current classroom placement:  Regular Education  Special Education

Specify type of placement: Click or tap here to enter text.

Does your child have an IEP? Choose an item. If yes, what is the classification: Click or tap here to enter text.

Has your child ever skipped or repeated a grade? Choose an item. Explain: Click or tap here to enter text.

Has your child attended summer school? Choose an item. Explain: Click or tap here to enter text.

Has your child taken any enrichment courses? Choose an item. Explain: Click or tap here to enter text.

Has your child been tested by the school? Choose an item. Explain: Click or tap here to enter text.

Has your child received any additional services not through an IEP (e.g. resource room, building-level supports)? Choose an item. Explain: Click or tap here to enter text.

In general, your child likes school: Choose an item.

In school, my child:

Gets along with other children and has friends OR  Does not get along with the other children

Gets along well with the teacher(s) OR  Does not get along with the teacher(s)

Describe any teacher concerns about your child’s schoolwork or behavior: Click or tap here to enter text.

Described your child’s current grades: Click or tap here to enter text.

Compared to previous years, current grades have:  improved  stayed the same  declined

My child’s best subjects are: Click or tap here to enter text.

My child’s hardest subjects are: Click or tap here to enter text.

**FAMILY HISTORY**

Please include all members of the family, including biological parents, step-parents, adoptive parents, and other people in the home:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** | **Age** | **Relationship** | **Education** | **Occupation** | **How is the relationship?** |
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Has anyone in the family received any of the following diagnoses:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Diagnosis** | **Relative(s)** | **Side of the Family**  **Mother Father** | | **Describe** |
| Developmental Delay |  |  |  |  |
| Brain or neurological disease |  |  |  |  |
| Epilepsy or Seizure Disorder |  |  |  |  |
| Genetic Disorder |  |  |  |  |
| Intellectual Deficit |  |  |  |  |
| Learning Disability |  |  |  |  |
| ADHD/ADD |  |  |  |  |
| Speech/Language Disorder |  |  |  |  |
| Psychiatric Disorder |  |  |  |  |
| Other (Specify) |  |  |  |  |

**COMMENTS**

What are your child’s interests and talents? Click or tap here to enter text.

What activities does your child enjoy or participate in? Click or tap here to enter text.

Please add any helpful comments, information, or concerns that have not previously been addressed. Click or tap here to enter text.