Child Psych Services, LLC

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CHILD NEUROPSYCHOLOGICAL HISTORY QUESTIONNAIRE*

Confidential

Patient's Name: _____

Completed By: _____ Relationship to Patient: _____

Today's Date: _____ Current Age: _____

Child's Date of Birth: _____ Grade: _____

Gender: ☐ Female ☐ Male

Handedness: ☐ Right ☐ Left ☐ Both

Ethnicity: ☐ African-American ☐ Hispanic ☐ Caucasian ☐ Native American
☐ Asian ☐ Other: _____

Primary Language: ☐ English ☐ Other: _____

Address: _____ Day Phone: _____
_____ Evening Phone: _____

Email: _____

Referral Information

Who referred your child for an evaluation? _____

Has your child ever had psychological or neuropsychological testing done before?

☐ No ☐ Yes, by: _____

Is this case involved in any litigation, or do you intend to pursue litigation in the future?

☐ Yes ☐ No

If Yes, please describe: _____

_____

_____

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Presenting Problems/Symptoms

Please describe what symptoms or problems are of most concern to you:

Please describe when and how you first became aware of these difficulties and whether they have gotten worse over time:

Do both parents agree about the nature of your child's problems? ☐ Yes ☐ No

Mother's Education: _____ **Occupation**: _____

Father's Education: _____ **Occupation**: _____

Please list all of members of family (parents & siblings)**:**

Name	Age	Relationship	Current health	How is the relationship?

Please list any members of your family who are left-handed:

Current Symptom Checklist

Please **check** each of the following symptoms or problems that your child is experiencing. Briefly describe each symptom checked (for example, intensity, how long it has been experienced, and how frequent it is):

Please Describe

- ☐ Headaches
- ☐ Dizziness
- ☐ Coordination problems
- ☐ Complaints of stomachaches
- ☐ Balance problems
- ☐ Poor eye contact with others
- ☐ Concentration problems
- ☐ Acts impulsively or without thinking
- ☐ Hearing or vision problems (please specify)
- ☐ Poor handwriting
- ☐ Difficulty pronouncing words clearly
- ☐ Getting tired easily
- ☐ Sensitivity to noise
- ☐ Sensitivity to light
- ☐ Behavioral problems at home
- ☐ Behavioral problems at school
- ☐ Being easily distractible
- ☐ Poor concentration for extended periods of time
- ☐ Difficulty reading or writing
- ☐ Difficulty thinking clearly and efficiently
- ☐ Difficulty planning and organizing things
- ☐ Difficulty following through or finishing things
- ☐ Apathy, lack of interest in things
- ☐ Difficulty starting tasks
- ☐ Trouble adjusting to changes in routine or environment
- ☐ Irritability
- ☐ Restlessness
- ☐ Temper outbursts
- ☐ Mood swings, quick emotional shifts
- ☐ Getting bored easily
- ☐ Bedwetting
- ☐ Anxiety/tension

. . . . **Symptom Checklist** continued

- ☐ Depression
- ☐ Loneliness
- ☐ Loss of confidence
- ☐ Feelings of guilt
- ☐ Changes in appetite
- ☐ Daydreaming
- ☐ Difficulty telling right from left
- ☐ Poor orientation to time; loses track of time
- ☐ Forgetting conversations and people's names
- ☐ Easily frustrated
- ☐ Feeling slowed down; slowed thinking/responding
- ☐ Sleep disturbance; change in sleep pattern
- ☐ Difficulty making/keeping friends
- ☐ Bullying others or victim of bullying (please specify)
- ☐ Other:

Developmental History

Pregnancy and Birth History:

Did conception require medical assistance? (i.e., medication to induce ovulation; In Vitro Fertilization) ☐ No ☐ Yes, please briefly describe: _____

Age of mother at delivery: _____ **Birth weight** (pounds & ounces)**:** _____
Age of father at delivery: _____ **Apgar scores:** ____ 1 minute ____ 5 minute

Delivery was: ☐ Vaginal ☐ Planned Cesarean ☐ Emergency Cesarean ☐ Induced

Did the baby breathe spontaneously? _____

Baby was born: ☐ Full term ☐ Premature at ____ weeks gestation ☐ Post term at ___ weeks
Assistance used: ☐ Forceps ☐ Vacuum extraction

Were there any problems during the pregnancy or delivery? ☐ Yes ☐ No
(i.e., meconium staining, cord around baby's neck, high bilirubin level or jaundice) _____

_____

_____

Did mother use any prescription or other medications, alcohol, drugs, smoke, or have x-rays during pregnancy? ☐ Yes ☐ No
If Yes, please describe: _____

_____

_____

Developmental Milestones

Did your child…	**Yes / No**
Sit up by 8 months? If no: _____ months	Y N
Crawl by 10 months? If no: _____ months	Y N
Walk by 15 months? If no: _____ months	Y N
Speak first word by 1 year? If no: _____ months	Y N
Speak in 2 word sentences by 2 years? If no: _____ months	Y N
Could strangers understand your child by 3 years?	Y N
Toilet trained during the day by 3.5 years?	Y N
Dry at night by 5 years?	Y N
Read simple words by 6 years?	Y N

Did your child experience…	**Yes / No**
Urine accidents?	Y N
Stool/bowel accidents (soiling)?	Y N
Difficulty falling asleep or disruptive bedtime behavior?	Y N
Difficulty staying asleep or staying in bed at night?	Y N
Difficulty waking up in the morning?	Y N
Difficulty with self-care (feeding, washing, toileting)?	Y N
Difficulty with learning to button, zip, or dress?	Y N
Difficulty learning to throw and catch a ball?	Y N
Difficulty learning to name colors or shapes?	Y N
Difficulty learning to name letters or numbers?	Y N
Difficulty learning to ride a tricycle or bicycle?	Y N

Did your child seem to develop normally but then lose developmental skills? Y N

If yes, describe: _____

Has the child or anyone in the family received any of the following diagnoses:

	Child	**Family**
Language delay or difficulty	Y N DK	Y N DK
Autism Spectrum Disorder	Y N DK	Y N DK
Hyperactivity in Childhood	Y N DK	Y N DK
Attention Deficit/Hyperactivity Disorder	Y N DK	Y N DK
Learning Disability	Y N DK	Y N DK
Depression	Y N DK	Y N DK
Schizophrenia	Y N DK	Y N DK
Bipolar Disorder	Y N DK	Y N DK
Any psychiatric diagnosis	Y N DK	Y N DK
Maturation lag / developmental delay	Y N DK	Y N DK
Emotional / behavior problems	Y N DK	Y N DK
Anxiety	Y N DK	Y N DK

If Yes, please describe their relationship to your child: _____

Please list any special talents, interests, or hobbies that your child has:

_____

_____

_____

_____

Has your child had any contact with the law? ☐ Yes ☐ No

If Yes, explain (include dates and nature of the violations): _____

_____

_____

_____

Educational History

Current School: _____ **Primary Teacher:** _____

Placement: ☐ Regular ☐ Special Education

Does your child have an IEP? _____ **If yes, under what category?** _____

Has your child ever skipped or repeated a grade in school? ☐ Yes ☐ No

If Yes, explain: _____

_____

Has your child ever received additional services at school? ☐ Yes ☐ No

(i.e., learning or emotional support, tutoring, gifted program, speech or occupational therapy)

If Yes, explain: _____

_____

_____

Has your child ever received any special education testing? ☐ Yes ☐ No

If Yes, explain: _____

_____

_____

Has your child ever participated in Early Intervention services? (i.e., Occupational Therapy, Physical Therapy, Speech therapy, etc.) ☐ Yes ☐ No

If Yes, please describe: _____

_____

_____

Did your child have any difficulties learning to read or write? ☐ Yes ☐ No

If Yes, explain: _____

_____

_____

Any problems learning addition, subtraction, multiplication or division? ☐ Yes ☐ No

If Yes, explain: _____

_____

On average, how would you describe your child's grades:

_____

_____

_____

Has your child participated in academic tutoring services? Please describe:

_____

_____

_____

Medical History

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

Illness/Condition	Dates	Treatment

Has your child ever had a head injury with loss of consciousness or being "dazed"?

☐ No ☐ Yes (Please describe)

Type of Head Injury	Date	Loss of Consciousness?	Outcome

Please list any neurological tests such as MRI, CT, or EEG, including dates and hospitals:

Test (Hospital)	Dates	Results

Check if your child has ever experienced the following and briefly describe:

- ☐ Head injury
- ☐ Seizures, convulsions, epilepsy
- ☐ Febrile seizure
- ☐ Chronic headaches
- ☐ Chronic ear infections
- ☐ High fevers
- ☐ Fainting spells
- ☐ Pneumonia
- ☐ Asthma
- ☐ Diabetes
- ☐ Irregular heart rhythm
- ☐ Repetitive movements (i.e., hand flapping)
- ☐ Change in sense of smell or taste
- ☐ Hearing problems
- ☐ Vision problems
- ☐ Electrical shock
- ☐ Exposure to toxic chemicals
- ☐ Hallucinations

Please list your child's current medications:

Medication	Amount	Taking Since?	Reason

Please list your child's past medications:

Medication	Amount	How Long?	Reason for stopping

Please list any known allergies:

☐ No Known Allergies

Please indicate if anyone in the family has had the following conditions by checking the box and putting their relationship to your child in the space provided:

☐ Diabetes		☐ Epilepsy	
☐ Hypertension		☐ Multiple Sclerosis	
☐ Heart Disease		☐ Parkinson's	
☐ Early Stroke		☐ Alzheimer's	
☐ Childhood Cancer		☐ Alcoholism	

Please describe any other relevant family medical history:

Psychiatric History

Please describe your child's psychiatric/psychological history from the time of first symptom to the present:

Has your child ever used tobacco products? ☐ Yes ☐ No

If Yes, please describe:

Has your child ever consumed alcoholic beverages? ☐ Yes ☐ No

If Yes, please describe (what, amount, frequency):

Has your child ever used illicit or "street" drugs (for example: marijuana, cocaine, heroin, etc.)? ☐ Yes ☐ No

If Yes, please describe (which, frequency):

Please provide names and dates of all psychiatric/psychological treatment or hospitalizations:

Clinician or Hospital	Dates	Problem and Treatment

Please describe any other family history of psychiatric problems:

Please add any additional information that you feel may be useful: