Portsmouth Neuropsychology Center, LLC
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Portsmouth, NH 03801
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CHILD
NEUROPSYCHOLOGICAL HISTORY

Date Completed _____

Client Information:

Client's name _____

D.O.B. _____ Age _____ Grade _____ Sex _____

School _____ Teacher _____

School Phone _____ 504, IEP, or other services: _____

Hand client uses for writing / drawing: Right _____ Left _____ Switches _____

Primary language _____ Secondary language _____

Client lives with: both parents___ mother ___ father ___ other:_____

Family Information:

Mother's Name _____

Address (Street, City, ST, Zip) _____

Phone (H) _____ (W)_____ (C) _____

E-mail _____

Father's Name _____

Address (Street, City, ST, Zip) _____

Phone (H) _____ (W)_____ (C) _____

E-mail _____

Names and ages of siblings _____

_____

Names and ages of others in household _____

Medical Information:

Primary Care Provider _____

Address _____ Phone _____

Current Medical diagnosis (1) _____

if any (2) _____

Current Medication(s) (names and dosages) _____

_____

Previous/current therapies or testing _____

_____

Who referred you for this consultation? _____

Describe the problems, first major concerns and then minor ones: _____

_____

_____

_____

_____