

**Portsmouth Neuropsychology Center, LLC**

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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 \_\_\_\_\_

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**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 the child for this testing? \_\_\_\_\_

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

What are your child's strengths? \_\_\_\_\_

What specific questions would you like answered by this evaluation?

(1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

## DETAILED HISTORY

### SYMPTOM SURVEY

Comparing your child to other children of the same age, determine whether each symptom applies. Next, check if this is a **NEW** symptom (within the past year) or an **OLD** symptom (over one year). Add any helpful comments next to the item.

#### PROBLEM SOLVING

New	Old	
_____	_____	Difficulty figuring out how to do new things
_____	_____	Difficulty making decisions
_____	_____	Difficulty solving problems a younger child can do
_____	_____	Difficulty understanding explanations
_____	_____	Difficulty doing things in the right order (sequencing)
_____	_____	Difficulty verbally describing the steps involved in doing something
_____	_____	Difficulty completing an activity in a reasonable period of time
_____	_____	Difficulty changing a plan or activity when necessary
_____	_____	Is slow to learn new things
_____	_____	Difficulty switching from one activity to another activity
_____	_____	Easily frustrated
_____	_____	Other problem solving difficulties _____

#### SPEECH, LANGUAGE, AND MATH SKILLS

New	Old	
_____	_____	Difficulty speaking clearly
_____	_____	Difficulty finding the right word to say
_____	_____	Not talking
_____	_____	Rambles on and on without saying much
_____	_____	Jumps from topic to topic
_____	_____	Odd or unusual language or vocal sounds
_____	_____	Difficulty understanding what others are saying
_____	_____	Difficulty understanding what he/she is reading
_____	_____	Difficulty writing letters or words
_____	_____	Difficulty reading letters or words
_____	_____	Difficulty with spelling
_____	_____	Difficulty with math
_____	_____	Other speech, language, or math problems: _____

#### SPATIAL SKILLS

New	Old	
_____	_____	Confusion telling right from left
_____	_____	Has difficulty with puzzles, Legos, blocks, or similar games
_____	_____	Problems drawing or copying
_____	_____	Doesn't know his/her colors
_____	_____	Difficulty dressing (not due to physical difficulty)
_____	_____	Problems finding his/her way around places he/she has been to before
_____	_____	Difficulty recognizing objects
_____	_____	Seems unable to recognize facial or body expressions of disapproval or emotions
_____	_____	Gets lost easily
_____	_____	Other spatial problems: _____

## AWARENESS AND CONCENTRATION

New	Old	
_____	_____	Easily distracted by: Sounds ____ Sights ____ Physical sensations ____
_____	_____	Mind appears to go blank at times
_____	_____	Loses train of thought
_____	_____	Difficulty concentrating on what others say, but can sit in front of a TV for long periods
_____	_____	Attention starts out OK but can't keep it up
_____	_____	Other attention or concentration problems: _____

## MEMORY

New	Old	
_____	_____	Forgets where he/she leaves things
_____	_____	Forgets things that happened recently (e.g., last meal)
_____	_____	Forgets things that happened days/weeks ago
_____	_____	Forgets what he/she is supposed to be doing
_____	_____	Forgets names more than most people do
_____	_____	Forgets school assignments
_____	_____	Forgets instructions
_____	_____	Other memory problems: _____

## MOTOR AND COORDINATION

New	Old	
_____	_____	Poor fine motor skills (e.g., using a pencil or crayon)
_____	_____	Clumsy
_____	_____	Weakness
_____	_____	Tremor
_____	_____	Muscles are tight or spastic
_____	_____	Odd movements (posturing, peculiar hand movements, etc.)
_____	_____	Drops things more than most children
_____	_____	Has an unusual walk
_____	_____	Balance problems
_____	_____	Other motor or coordination problems: _____

## SENSORY

New	Old	
_____	_____	Needs to squint or move closer to page to read
_____	_____	Problems seeing objects
_____	_____	Loss of feeling
_____	_____	Problems hearing sounds
_____	_____	Difficulty telling hot from cold
_____	_____	Difficulty smelling odors
_____	_____	Difficulty tasting food
_____	_____	Overly sensitive to: Touch____ Light____ Noise____
_____	_____	Other sensory problems: _____

## PHYSICAL

New	Old		How often?
_____	_____	Frequently complains of headaches or nausea	_____
_____	_____	Has dizzy spells	_____
_____	_____	Has pains in joints Where? _____	_____
_____	_____	Excessive tiredness	
_____	_____	Frequent urination or drinking	
_____	_____	Other physical problems: _____	

**BEHAVIOR**

New	Old		New	Old	
_____	_____	Aggressive	_____	_____	Nervous
_____	_____	Attached to things, not people	_____	_____	Quiet
_____	_____	Bedwetting	_____	_____	Unmotivated
_____	_____	Bizarre behavior	_____	_____	Resists change
_____	_____	Bowel movements in underwear	_____	_____	Risk-taking
_____	_____	Dependent	_____	_____	Self-mutilates
_____	_____	Depressed	_____	_____	Self-stimulates
_____	_____	Eating habits are poor	_____	_____	Shy and withdrawn
_____	_____	Emotional	_____	_____	Sleeping habits are poor
_____	_____	Fearful	_____	_____	Swears a lot
_____	_____	Immature	_____	_____	Nightmares, night terrors, sleepwalks
_____	_____	Other unusual behavior: _____			

Below, check all the descriptions of the child that have been present for at least the past 6 months. These behaviors should occur more frequently than in other children of the same age:

_____	Is very fidgety	_____	Steals things without people knowing on several occasions
_____	Can't remain seated	_____	Starts fights with others
_____	Doesn't listen to other people	_____	Easily lies to others
_____	Is cruel to other people	_____	Fire setting
_____	Highly distractible	_____	Doesn't go to school
_____	Can't wait for his/her turn when playing with others	_____	Often runs away from his parents' home and stays away overnight
_____	Answers before he/she hears the whole question	_____	Is cruel to animals
_____	Rarely follows others' instructions	_____	Will steal directly from people
_____	Has a hard time concentrating for long periods	_____	Has forceable sexual relations with other
_____	Destroys other people's property in some manner other than by fire	_____	Is often rude or interrupts others
_____	Goes from one activity to another without finishing anything	_____	Seems like he/she frequently is losing things that are needed for school
_____	Frequently makes noise when playing		
_____	Seems like he/she is always talking		
_____	When fighting, has used a weapon on more than 1 occasion		
_____	Frequently does dangerous things without considering the consequences		

Overall, the child's symptoms have developed: \_\_\_\_\_ Slowly \_\_\_\_\_ Quickly

The symptoms occur: \_\_\_\_\_ Occasionally \_\_\_\_\_ Often

Over the past 6 months the symptoms have: \_\_\_\_\_ Stayed about the same \_\_\_\_\_ Worsened

## FAMILY HISTORY

The child lives with:

\_\_\_\_\_ Biological parent(s) only      \_\_\_\_\_ Relatives      \_\_\_\_\_ Foster parents  
\_\_\_\_\_ Biological parent and other      \_\_\_\_\_ Adoptive parent(s)\*\*      \_\_\_\_\_ Institutional care  
\_\_\_\_\_ Other placement \_\_\_\_\_

**\*\*For parents of adoptive children please go to pages 12-13\*\***

What is the name of the child's biological mother? \_\_\_\_\_

a. Is she living? Yes \_\_\_\_\_ No \_\_\_\_\_ If deceased, explain: \_\_\_\_\_

b. Her age? \_\_\_\_\_

c. What is her level of education? \_\_\_\_\_

d. Her occupation? \_\_\_\_\_

e. Does she live in the same house as the child? Yes \_\_\_\_\_ No \_\_\_\_\_

f. How often does she see the child? \_\_\_\_\_

g. How involved is the mother in the child's upbringing? Very \_\_\_\_\_ Somewhat \_\_\_\_\_ Not at all \_\_\_\_\_

h. Did the mother have a learning disability or other problems when she was in school? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, describe: \_\_\_\_\_

What is the name of the child's biological father? \_\_\_\_\_

a. Is he living? Yes \_\_\_\_\_ No \_\_\_\_\_ If deceased, explain: \_\_\_\_\_

b. His age? \_\_\_\_\_

c. What is his level of education? \_\_\_\_\_

d. His occupation? \_\_\_\_\_

e. Does he live in the same house as the child? Yes \_\_\_\_\_ No \_\_\_\_\_

f. How often does he see the child? \_\_\_\_\_

g. How involved is the father in the child's upbringing? Very \_\_\_\_\_ Somewhat \_\_\_\_\_ Not at all \_\_\_\_\_

h. Did the father have a learning disability or other problems when he was in school? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, describe: \_\_\_\_\_

Has anyone in the child's biological family (including parents, grandparents, siblings, cousins, aunts & uncles) ever had any of the following?

	Which relative?	Describe the problem briefly
_____ Brain disease	_____	_____
_____ Developmental delay	_____	_____
_____ Epilepsy or seizures	_____	_____
_____ Learning disability	_____	_____
_____ Intellectual disability	_____	_____
_____ Neurologic disease	_____	_____
_____ Psychological problems	_____	_____
_____ Reading or spelling difficulties	_____	_____
_____ Speech or language problems	_____	_____
_____ Drug or Alcohol Abuse/Addiction	_____	_____
_____ Other	_____	_____

Which of the child's biological relatives are left-handed?

Mother \_\_\_\_\_ Father \_\_\_\_\_ Sibling(s) \_\_\_\_\_ Grandparents \_\_\_\_\_ No one \_\_\_\_\_

What languages are spoken in the home?

(List in order of the most frequent first.)

(1) \_\_\_\_\_

(2) \_\_\_\_\_

How is the child disciplined? \_\_\_\_\_

List the child's usual recreational activities and hobbies:

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Have there been any major family stresses or changes in the past year (e.g., moving with change of school, divorce, significant illness, etc.)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

How much stress have these changes caused the child? (circle one)

None

Mild

Moderate

Severe

## PREGNANCY

Mother's age at child's birth: \_\_\_\_\_ Father's age at child's birth: \_\_\_\_\_

**Before** the pregnancy, what medications (prescribed or over-the-counter) did the mother take?

List all medications used: \_\_\_\_\_

**While** pregnant, what medications (prescribed or over-the-counter) did the mother take?

List all medications used: \_\_\_\_\_

How often did the mother see her doctor during the pregnancy?

Regularly (as scheduled by the doctor) \_\_\_\_\_

Rarely \_\_\_\_\_

Not at all \_\_\_\_\_

During the pregnancy, which of the following did the mother use?

**Amount and Daily Frequency**

_____ Alcohol	_____
_____ Caffeine (coffee, colas, etc.)	_____
_____ Marijuana	_____
_____ Recreational drugs (cocaine, heroin, etc.)	_____
_____ Tobacco	_____

During the pregnancy, the mother's diet was:

Good \_\_\_\_\_

Poor \_\_\_\_\_

If poor, explain: \_\_\_\_\_

The mother's general physical health during the pregnancy was: Good \_\_\_\_\_

Poor \_\_\_\_\_

If poor, explain: \_\_\_\_\_

About how much weight did the mother gain while she was pregnant? \_\_\_\_\_ lbs.

During this pregnancy, check all the mother had:

<input type="checkbox"/> Accident	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Anemia	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Bleeding (severe or frequent spotting)	<input type="checkbox"/> Illnesses or infections
<input type="checkbox"/> Preeclampsia, eclampsia, or toxemia	<input type="checkbox"/> Psychological problems
<input type="checkbox"/> Surgery	<input type="checkbox"/> Vomiting (severe or frequent)

How many pregnancies did the mother have prior to this one?

Number of live births: \_\_\_\_\_

Number of miscarriages: \_\_\_\_\_

## BIRTH

Was this child born:

Early \_\_\_\_\_ How early? \_\_\_\_\_ weeks

On time \_\_\_\_\_ (38 - 42 weeks)

Late \_\_\_\_\_ How late? \_\_\_\_\_ Weeks

How much did the baby weigh at birth? \_\_\_\_\_ lbs. \_\_\_\_\_ oz. OR \_\_\_\_\_ gms.

How long did the labor last? \_\_\_\_\_

The labor was: Easy \_\_\_\_\_ Moderately difficult \_\_\_\_\_ Very difficult \_\_\_\_\_

What type of medication was the mother given to help with delivery?

Demerol \_\_\_\_\_ Gas \_\_\_\_\_ Regional nerve (spinal) block \_\_\_\_\_ None \_\_\_\_\_ Tranquilizer \_\_\_\_\_ Epidural \_\_\_\_\_

Were forceps used during delivery? Yes \_\_\_\_\_ No \_\_\_\_\_

Was the baby born:

Head first \_\_\_\_\_ Transverse (crosswise) \_\_\_\_\_ Posterior first \_\_\_\_\_

Breech birth \_\_\_\_\_ Caesarean section \_\_\_\_\_ Vacuum extraction \_\_\_\_\_

Other: \_\_\_\_\_

Did the baby experience any of these problems:

Fetal distress \_\_\_\_\_ Low placenta (Placenta previa) \_\_\_\_\_ Prolapsed cord \_\_\_\_\_

Premature separation of placenta (Abruptio placenta) \_\_\_\_\_ Cord wrapped around neck \_\_\_\_\_

Describe any other special problems the mother or child had during delivery:

At birth, did the baby:

Have difficulty breathing? Yes \_\_\_\_\_ No \_\_\_\_\_

Fail to cry? Yes \_\_\_\_\_ No \_\_\_\_\_

Appear inactive? Yes \_\_\_\_\_ No \_\_\_\_\_

List the baby's Apgar scores: 1st \_\_\_\_\_ 2nd \_\_\_\_\_

If the father or mother noticed anything unusual when they first saw the baby, describe:

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If the baby was born with any problems (congenital defects, large or small head, blue baby, bleeding in brain, etc.), describe: \_\_\_\_\_

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Describe any special problems that the baby had in the first few days following birth:

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Describe any special care, treatment, or equipment the child was given after birth:

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How long did the baby stay in the hospital? \_\_\_\_\_

## DEVELOPMENTAL HISTORY

For each area, indicate the child's health by circling one description. The "Average" period is only a rough idea of what is average since every developmental milestone actually involves a range of several months (e.g., walking occurs approximately 9-18 months of age). Circle "Early" or "Late" only if you are sure the child's development was different from that of most other children.

### GROSS MOTOR SKILLS

Crawled	Early	Average (6-9 months)	Late
Walked alone (2-3 steps)	Early	Average (9-18 months)	Late

### LANGUAGE

Followed simple commands	Early	Average (12-18 months)	Late
Used single-word sentences	Early	Average (12-24 months)	Late

### SELF-HELP

Toilet trained	Early	Average (13-36 months)	Late
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List any other significant developmental problems:

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Overall, the child's development was: Early \_\_\_\_\_ Average \_\_\_\_\_ Late \_\_\_\_\_

As an infant or toddler, did the child have poor muscle control (i.e., weakness) of the:

Neck \_\_\_\_\_ Trunk \_\_\_\_\_ Legs \_\_\_\_\_ Arms \_\_\_\_\_

As an infant or toddler, did the child's muscles seem to be unusually tight or stiff?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, describe: \_\_\_\_\_

Toilet training was: Easy \_\_\_\_\_ Difficult \_\_\_\_\_

As an infant or toddler, the child was:

Too calm and inactive	_____
Calm and reasonably active	_____
Irritable and very active	_____

As a toddler, the child was:

Shy and inhibited	_____
Neither shy nor outgoing	_____
Very outgoing and like people	_____

Did the child have a poor appetite as a baby? Yes \_\_\_\_\_ No \_\_\_\_\_

Did the child fail to gain weight steadily as a baby? Yes \_\_\_\_\_ No \_\_\_\_\_

List the baby's illnesses or physical problems during the first year:

\_\_\_\_\_

\_\_\_\_\_

Has the child had a temperature of 104°F (40°C) or higher for more than a few hours?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what age(s)? \_\_\_\_\_ and how long did it last \_\_\_\_\_

Has the child ever been hit hard on the head or suffered a head injury? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what age(s)? \_\_\_\_\_ Did the child lose consciousness? Yes \_\_\_\_\_ No \_\_\_\_\_

How did it happen? \_\_\_\_\_

What problems did the child have (physical or mental) afterwards?

\_\_\_\_\_

Did the child ever have a seizure due to a fever or unknown cause? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, describe (age, nature of seizure): \_\_\_\_\_

Has the child been diagnosed with seizures or epilepsy? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, which type? Partial seizure \_\_\_\_\_ Generalized seizure \_\_\_\_\_ Unclassified type \_\_\_\_\_

If medication is used, what medication(s)? \_\_\_\_\_

Has the child ever had a bad reaction to this medication? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, describe: \_\_\_\_\_

Was the child ever in the hospital for an accident, injury, or operation? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what age(s)? \_\_\_\_\_ What happened? \_\_\_\_\_

Has the child ever swallowed any poison, non-food, or drug accidentally? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what age(s)? \_\_\_\_\_ What happened: \_\_\_\_\_

Did the child have frequent ear infections? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what age(s)? \_\_\_\_\_ How often and severe? \_\_\_\_\_

What treatment was provided? \_\_\_\_\_

Please check all the following diseases or conditions the child has ever had:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Mumps
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Kidney disorder	<input type="checkbox"/> Oxygen deprivation
<input type="checkbox"/> Asthma	<input type="checkbox"/> Colds (excessive)	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver disorder	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Blood disorder	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Lung disorder	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Brain disorder	<input type="checkbox"/> Enzyme deficiency	<input type="checkbox"/> Measles	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Broken bones	<input type="checkbox"/> Genetic disorder	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart disorder	<input type="checkbox"/> Metabolic disorder	<input type="checkbox"/> Whooping cough

Other problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

As the child has been growing up, he/she has been sick:

Much of the time \_\_\_\_\_

An average amount \_\_\_\_\_

Not much at all \_\_\_\_\_

*If your child was not adopted please skip to page 14.*

### **ADOPTIVE FAMILY HISTORY**

When did the adoption occur? \_\_\_\_\_

How old was child when adopted? \_\_\_\_\_

Do you have any information about your child's in utero health and birth?

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Do you have any information about your child's home environment pre-adoption?

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Do you have any information about when your child met early language and motor milestones?

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What is the name of the child's adoptive mother? \_\_\_\_\_

a. Is she living? Yes \_\_\_\_\_ No \_\_\_\_\_ If deceased, explain: \_\_\_\_\_

b. Her age? \_\_\_\_\_

c. What is her level of education? \_\_\_\_\_

d. Her occupation? \_\_\_\_\_

e. Does she live in the same house as the child? Yes \_\_\_\_\_ No \_\_\_\_\_

f. How often does she see the child? \_\_\_\_\_

g. How involved is the mother in the child's upbringing? Very \_\_\_\_\_ Somewhat \_\_\_\_\_ Not at all \_\_\_\_\_

What is the name of the child's adopted father? \_\_\_\_\_

a. Is he living? Yes \_\_\_\_\_ No \_\_\_\_\_ If deceased, explain: \_\_\_\_\_

b. His age? \_\_\_\_\_

c. What is his level of education? \_\_\_\_\_

d. His occupation? \_\_\_\_\_

e. Does he live in the same house as the child? Yes \_\_\_\_\_ No \_\_\_\_\_

f. How often does he see the child? \_\_\_\_\_

g. How involved is the father in the child's upbringing? Very \_\_\_\_\_ Somewhat \_\_\_\_\_ Not at all \_\_\_\_\_

**Adoptive Family History (cont.)**

What languages are spoken in the home? (List in order of the most frequent first.)

(1) \_\_\_\_\_ (2) \_\_\_\_\_

How is the child disciplined? \_\_\_\_\_

List the child's usual recreational activities and hobbies:

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Have there been any major family stresses or changes in the past year (e.g., moving with change of school, divorce, significant illness, etc.)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

How much stress have these changes caused the child? (circle one)

None

Mild

Moderate

Severe

## SCHOOL HISTORY

Please summarize the child's progress (e.g., academic, social, testing) within each of these grade levels (include school name, if possible):

Preschool \_\_\_\_\_

Kindergarten \_\_\_\_\_

Grades 1 through 3 \_\_\_\_\_

Grades 4 through 6 \_\_\_\_\_

Grades 7 through 12 \_\_\_\_\_

Has the child ever been in any type of special educational program, and if so, how long? (If yes, please explain.)

\_\_\_\_\_ Learning disabilities class

\_\_\_\_\_ Speech & language therapy

\_\_\_\_\_ Duration of placement

\_\_\_\_\_ Duration of therapy

\_\_\_\_\_ Behavioral/emotional disorders class

\_\_\_\_\_ Other (please specify)

\_\_\_\_\_ Duration of placement

\_\_\_\_\_ Duration

Has the child ever been: (If yes, please explain.)

\_\_\_\_\_ Suspended from school

\_\_\_\_\_ Number of expulsions

\_\_\_\_\_ Number of suspensions

\_\_\_\_\_ Retained in grade

\_\_\_\_\_ Expelled from school

\_\_\_\_\_ Number of retentions

Have any additional instructional modifications been attempted? (If yes, please explain.)

\_\_\_\_\_ None

\_\_\_\_\_ Behavior modification program

\_\_\_\_\_ Daily/weekly report card

\_\_\_\_\_ Occupational Therapy

\_\_\_\_\_ Tutoring

\_\_\_\_\_ Other (please explain)

Does the child like school?      Most of the time \_\_\_\_\_      Sometimes \_\_\_\_\_      Almost never \_\_\_\_\_

Does the child:

Have problems with other children in class?

Yes \_\_\_\_\_ No \_\_\_\_\_

Have problems making friends in school?

Yes \_\_\_\_\_ No \_\_\_\_\_

Have problems getting along with teachers?

Yes \_\_\_\_\_ No \_\_\_\_\_

Tend to get sick in the morning before school?

Yes \_\_\_\_\_ No \_\_\_\_\_

Describe the teacher's current concerns about the child's schoolwork or behavior:

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What kind of grades has the child received in the past year?

A's & B's \_\_\_\_\_ B's & C's \_\_\_\_\_ C's & D's \_\_\_\_\_ D's & F's \_\_\_\_\_

or

Outstanding \_\_\_\_\_ Good \_\_\_\_\_ Satisfactory \_\_\_\_\_ Improvement needed \_\_\_\_\_ Unsatisfactory \_\_\_\_\_

or

Other grading system: \_\_\_\_\_

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Are these grades a change from previous years?

Yes \_\_\_\_\_ No \_\_\_\_\_

In the past year, how much school has the child missed due to illness or injury?

Less than 2 weeks \_\_\_\_\_ 2 to 4 weeks \_\_\_\_\_ 5 to 8 weeks \_\_\_\_\_ Over 8 weeks \_\_\_\_\_

Briefly describe the reasons if the child has missed a lot of school:

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Does the child seem to have a "school phobia"?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain: \_\_\_\_\_

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## **SOCIAL HISTORY**

How does the child get along with his/her brothers/sisters?

- \_\_\_\_\_ Doesn't have any
- \_\_\_\_\_ Better than average
- \_\_\_\_\_ Average
- \_\_\_\_\_ Worse than average

How easily does the child make friends?

- \_\_\_\_\_ Easier than average
- \_\_\_\_\_ Average
- \_\_\_\_\_ Worse than average
- \_\_\_\_\_ Don't know

On the average, how long does your child keep friendships?

- \_\_\_\_\_ Less than 6 months
- \_\_\_\_\_ 6 months to 1 year
- \_\_\_\_\_ More than 1 year
- \_\_\_\_\_ Don't know

PREVIOUS EVALUATIONS

Which of these tests or procedures recently have been done?	Note any abnormal findings.	
<b>Evaluation</b>	<b>Check here if normal</b>	<b>Abnormal findings</b>
_____ Blood work	_____	_____
_____ Family physician or pediatrician office visit	_____	_____
_____ Hearing testing	_____	_____
_____ Lead level check	_____	_____
_____ Lumbar puncture or spinal tap	_____	_____
_____ Neurological examination or testing (CT scan, EEG)	_____	_____
_____ Psychological or neuropsychological testing	_____	_____
_____ School testing	_____	_____
_____ Speech & language testing	_____	_____
_____ Vision testing	_____	_____
_____ X-rays	_____	_____
_____ Other tests:		
_____		
_____		
_____		
_____		
_____		
_____		