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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 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:

_____

_____

_____

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:

_____ Accident	_____ Diabetes
_____ Anemia	_____ High blood pressure
_____ Bleeding (severe or frequent spotting)	_____ Illnesses or infections
_____ Preeclampsia, eclampsia, or toxemia	_____ Psychological problems
_____ Surgery	_____ 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? None _____
Demerol _____ Gas _____ Regional nerve (spinal) block _____ 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:

_____

_____

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

_____

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

_____

_____

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

_____

_____

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

List any other significant developmental problems:

_____

_____

_____

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 104ºF (40ºC) 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:

____ Allergies	____ Cerebral palsy	____ Jaundice	____ Mumps
____ Anemia	____ Chicken pox	____ Kidney disorder	____ Oxygen deprivation
____ Asthma	____ Colds (excessive)	____ Leukemia	____ Pneumonia
____ Bleeding disorder	____ Diabetes	____ Liver disorder	____ Rheumatic fever
____ Blood disorder	____ Encephalitis	____ Lung disorder	____ Scarlet fever
____ Brain disorder	____ Enzyme deficiency	____ Measles	____ Tuberculosis
____ Broken bones	____ Genetic disorder	____ Meningitis	____ Venereal disease
____ Cancer	____ Heart disorder	____ Metabolic disorder	____ 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?

_____

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

_____

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:

_____

_____

_____

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
_____ Duration of placement
_____ Behavioral/emotional disorders class
_____ Duration of placement
_____ Speech & language therapy
_____ Duration of therapy
_____ Other (please specify)
_____ Duration

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

_____ Suspended from school
_____ Number of suspensions
_____ Expelled from school
_____Number of expulsions
_____ Retained in grade
_____ 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:

_____

_____

_____

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: _____

_____

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:

_____

Does the child seem to have a "school phobia"? Yes _____ No _____
If yes, explain: _____

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.

Evaluation	**Check here if normal**	**Abnormal findings**
_____ 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:		

_____
_____
_____
_____
_____
_____