CHILD NEUROPSYCHOLOGY HISTORY QUESTIONNAIRE
NEURORESOURCES, PLLC.

All information is confidential. We understand it may be difficult to answer some of the questions asked. Please answer to the best of your ability.

CHILD'S NAME:_____ DATE: _____

ADDRESS: _____ CITY/STATE: _____

TELEPHONE: ( )_____ DATE OF BIRTH: _____

GENDER(Circle one): Male Female ETHNICITY: _____

HANDEDNESS(Circle one): Right Left Ambidextrous EDUCATION: _____ grade

This form was completed in whole, or in part, by: _____
Relationship to child: _____

With whom does the child reside? Please circle one:

Natural Parents	One Parent Alone	Parent & Step-Parent
Foster/Adoptive Parents	Legal Guardian	Other (specify): _____

Parents are (Circle one): Married Separated Divorced Widowed Unmarried

Father's Information:

Name: _____ Date of Birth: _____
Address (if other than child's): _____
City: _____ State: _____ Zip: _____
Occupation: _____Highest grade completed in school: _____
Work Phone: _____ Home Phone: _____

Mother's Information:

Name: _____ Date of Birth: _____
Address (if other than child's): _____
City: _____ State: _____ Zip: _____
Occupation: _____Highest grade completed in school: _____
Work Phone: _____ Home Phone: _____

Step-Parent's Information (If applicable):

Name: _____ Date of Birth: _____
Age of child when step-parent entered family: _____
Occupation: _____Highest grade completed in school: _____
Work Phone: _____ Home Phone: _____

Legal Guardian's Information (If different than biological parent(s) or step-parent(s)):

Name: _____ Date of Birth: _____
Address (if other than child's): _____
City: _____ State: _____ Zip: _____
Occupation: _____Highest grade completed in school: _____
Work Phone: _____ Home Phone: _____

EMERGENCY CONTACT #1: (Other than parent): (MUST BE COMPLETED)

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____

I. REFERRAL INFORMATION

Who referred you to this clinic? _____

What are the specific concerns you would like addressed in our assessment and interpretive sessions with you? (Please circle all that apply.)

Educational	Getting along with others	Social/Emotional
Medical/Neurological	Behavior or Activity Level	Speech Development
Intellectual	Motor Skills	Language Development

Other (Please explain) _____

Are there other concerns that prompted you to call NeuroResources?

_____
_____
_____
_____

II. FAMILY / SOCIAL HISTORY

1. Some of the children seen at NeuroResources have been placed in foster care. If this child is in foster care, please answer the following questions.

   If in foster care, name of foster parents: _____
   Reason for placement: _____
   How many out of home placements has this child had? _____
   Length of time in this placement: _____ Total # of placements: _____
   Name of DHS case worker: _____ Phone #: _____

   Other children in the home Age Relationship

   _____
   _____
   _____
   _____
   _____

2. Mother's History of Medical or Learning Problems:

_____
_____
_____

3. Father's History of Medical or Learning Problems:

_____
_____
_____

4. Recent Family Stress (Circle all that apply.)

None Separation/Divorce Unemployment/Financial Problems
Relocation DHS Issues Death of a Family Member
Other (please explain): _____
_____

5. Any Family History (Close Relatives) Of:

	Yes	No	Which Family Member
Learning Problems	_____	_____	_____
Slow Learning	_____	_____	_____
ADD / ADHD	_____	_____	_____
Cerebral Palsy	_____	_____	_____
Mental Retardation	_____	_____	_____
Speech/Language Disorders	_____	_____	_____
Autism / PDD	_____	_____	_____
Seizures	_____	_____	_____
Other Neurologic Problems	_____	_____	_____
Psychiatric Disorders	_____	_____	_____
Genetic Syndromes	_____	_____	_____
Alcoholism	_____	_____	_____
Drug Abuse	_____	_____	_____

Other (Please Explain): _____
_____

III. PREGNANCY AND BIRTH HISTORY

1. Birth Weight: _____ lbs. _____ oz.
2. Mother's age at the time of pregnancy: _____
   Father's age at the time of pregnancy: _____
3. Number of pregnancies of child's natural mother: _____
   Number of live births of child's natural mother: _____
4. Prenatal care began: _____ 1st Trimester _____ 2nd Trimester _____ 3rd Trimester
5. Problems with Pregnancy:

	Yes	No
Bleeding/Spotting	_____	_____
Injuries	_____	_____
Diabetic state in pregnancy (sugar in urine)	_____	_____
High blood pressure	_____	_____
Infections	_____	_____
Toxic Exposure	_____	_____
Preterm Labor	_____	_____

Maternal weight gain: _____ lbs
Fetal Activity: _____ Normal _____ Increased _____ Decreased
Prescribed Medications: _____
_____
Other Problems: _____
_____

6. During your pregnancy did the child's mother use:

	Yes	No
Alcohol	_____	_____
Tobacco	_____	_____
Drugs	_____	_____

If Yes, what? _____
_____

7. Length of Pregnancy: _____ weeks
8. Labor: _____ Spontaneous _____ Induced How long was the labor? _____
9. Delivery: _____ Vaginal _____ Forceps / Vacuum assisted _____ Cesarean
   If Cesarean, why? _____
10. Did the baby require oxygen, resuscitation, or reviving after birth? ___ Yes ___ No
    If yes, why? _____
    What were the baby's Apgar scores? _____
11. Did the baby stay in intensive care or the regular nursery? _____
12. Place of birth: _____ Name of Hospital: _____
13. Discharge from hospital at _____ days of life

Problems in the Nursery:	Yes	No		Yes	No
Problems breathing	_____	_____	Infections (sepsis)	_____	_____
High or low blood sugar	_____	_____	Seizures	_____	_____
High or low temperature	_____	_____	Feeding Problems	_____	_____
Jaundice (yellow skin)	_____	_____	Heart Problems	_____	_____
Bleeding in head	_____	_____			

Other: _____

IV. DEVELOPMENTAL HISTORY

1. Speech/Language (talking, understanding, communication with others)

   Do you think your child functions at his / her age level? Yes No

   If not, at what age level does he / she seem to function? _____

   Do you have any concerns in this area? Yes No

2. Motor Development (rolling over, sitting, walking, buttoning, writing, etc.)

   Do you think your child functions at his / her age level? Yes No

   If not, at what age level does he / she seem to function? _____

   Do you have any concerns in this area? Yes No

3. Cognitive (problem solving, following instructions, learning in school, intellectual abilities)

   Do you think your child functions at his / her age level? Yes No

   If not, at what age level does he / she seem to function? _____

   Do you have any concerns in this area? Yes No

4. Social-Emotional (expressing feelings & needs, getting along with others, attachment, behavior)

   Do you think your child functions at his / her age level? Yes No

   If not, at what age level does he / she seem to function? _____

   Do you have any concerns in this area? Yes No

V. HEALTH HISTORY (PAST MEDICAL HISTORY)

Who is your child's physician (doctor)? _____
Physician's address, city, state, zip, and phone number: _____
_____

Please give details of any medical problems or prior hospitalizations for your child (Use back of sheet if necessary). _____
_____
_____
_____

Has your child required any surgeries? ____ Yes _____ No Please explain. (Use back of sheet if necessary.) _____
_____
_____
_____

Has your child had any serious injuries, especially head injuries? _____ Yes _____ No
Please explain. (Use back of sheet if necessary.) _____
_____
_____
_____

Please list any prescription or non-prescription medications your child is taking on a regular basis? _____
_____
_____

Does your child have any allergies to foods or medications? _____ Yes _____ No
Please explain: _____
_____
_____

Are your child's immunizations (shots) current and up to date? _____ Yes _____ No

Does your child have any particular eating problems, especially food preferences? _____

_____

_____

VI. REVIEW OF SYSTEMS

Please check if your child has experienced any of the following:

Vision:
_____ Glasses/Contacts
_____ Blurred or Double Vision
_____ Loss of Vision/Blind Spots

Hearing:
_____ Hearing Aid (left, right, or both ears)
_____ Loss of Hearing
_____ Ringing
_____ Tone Deafness
_____ Ear infections (tubes placed)

Motor: (specify where)
_____ Decreased Coordination
_____ Weakness
_____ Paralysis
_____ Spasms/Tremors
_____ Chewing/Swallowing
_____ Range of Movement/Flexibility

Pain: (specify where)
_____ None
_____ Head (Constant OR Intermittent)
_____ Back (Constant OR Intermittent)
_____ Chest (Constant OR Intermittent)
_____ Abdominal (Constant OR Intermittent)
_____ Global (Constant OR Intermittent

Tactile: (specify where)
_____ Numbness/Loss of Sensation
_____ Tingling/Burning
_____ Pain/Temperature Sensitivity

Taste & Smell:
_____ Change in Taste
_____ Bad Tastes
_____ Change in Smell
_____ Bad Smells

Consciousness:
_____ Seizures or Fits
_____ Fainting or Blackout Spells
_____ Lapses of Time
_____ Dizziness While Sitting
_____ Dizziness Upon Standing
_____ Staring Episodes

Other:
_____ Asthma
_____ Aspiration
_____ Bladder / Bowel Problems
_____ Motor / Vocal Tics
_____ Sleep Difficulties
_____ Previous MRI or CT Scan

_____ Previous vision screen/ophthalmologic assessment
If yes, when? _____ _____ Normal _____ Abnormal

_____ Follow up ophthalmologic exam scheduled
What dates? _____

_____ Early Childhood Diseases (measles, mumps, chicken pox)
Please specify: _____

_____ Previous hearing screen/audiologic assessment
If yes, when? _____ _____ Normal _____ Abnormal

_____ Follow up audiologic exam scheduled
What dates?_____

COGNITIVE SYMPTOMS (Check all that apply):

Attention:

_____ Distractibility
_____ Confusion/Orientation Deficits (forgetting day, date, or wherabouts)
_____ Concentration Deficits (Must repeatedly read a book or newspaper before it makes sense. Cannot follow television show from start to finish)
_____ Path Finding Problems (Patient gets lost going to familiar places and/or has problems taking a bus)

Memory:

_____ Immediate Memory (names, faces, telephone numbers)
_____ Visual Memory Problems
_____ Verbal Memory Problems
_____ Memory Change (example) _____
_____ Short-term Recall - Difficulty remembering newly learned experience
_____ Long-term or Remote Recall - Difficulty remembering past experiences/events
_____ Absent-Mindedness
_____ Memory for Names/Faces
_____ Memory for Numbers
_____ Old Learning (e.g., taking a bus, cooking a meal/dish, simple math/spelling)
_____ New Learning (able to learn something new involving 3 or 4 steps)

Speech:

_____ Difficulty Expressing Thoughts
_____ Difficulty Understanding Others
_____ Change in Articulation/Slurred or Mumbled Speech
_____ Trouble Finding Correct Word or Desired Word
_____ Saying Wrong or Inappropriate Word
_____ Word-naming Problems
_____ Hesitations
_____ Substitutions
_____ Speech Impediments
_____ Difficulty Constructing Sentences

Thought Processes:

_____ Trouble Organizing Thoughts
_____ Trouble Organizing Actions
_____ Slowed Thinking
_____ Decreased Problem Solving Ability
_____ Changes in Ability to Read
_____ Changes in Ability to Write
_____ Changes in Ability to Spell
_____ Changes in Ability to do Math

EMOTIONAL SYMPTOMS:

_____ Crying
_____ Sadness
_____ Hyperactivity
_____ Temper Outbursts
_____ Irritability/Argumentativeness
_____ Impulsiveness
_____ Change in Motivation
_____ Loss of Pleasure
_____ Anxiety/Tension/Nervousness
_____ Fears
_____ Social Withdrawal/Isolation
_____ Change in Alcohol or Tobacco Consumption
_____ Racing Thoughts
_____ Worry

SLEEPING PROBLEMS:

_____ Sleep Change (specify) _____
_____ Early/Middle/Late Onset Problems
_____ Number of Hours per Night
_____ Diurnal Variations (daily)
_____ Still Able to Function Despite Sleep Problems
_____ Stress-related Sleep Difficulties

APPETITE CHANGE:

_____ Weight Loss/Gain
_____ Number of Times
_____ Intentional
_____ Libido Changes _____
_____ Mood Swings _____
_____ Agitation/Panic Attacks _____
_____ Hallucinations _____
_____ Delusions _____
_____ Suicide Attempts/Gestures/Ideation _____
_____ Suicidal Thoughts/Ideation _____
_____ Current
_____ Past

Additional Comments:

_____
_____
_____
_____
_____
_____
_____
_____

Below is a list of items that may describe children and adolescents. Read each item carefully and please answer all items as well as you can and consider how these items reflect your child over the **past 6 months**. For each item, please circle or mark as follows:

0 for **not true,**
1 for **somewhat or sometimes true**, or
2 for **very true or often true**

0 1 2 Acts too young for his/her age
0 1 2 Drinks alcohol without parents' approval
0 1 2 Argues a lot
0 1 2 Fails to finish things he/she starts
0 1 2 There is very little that he/she enjoys
0 1 2 Bowel movements outside toilet
0 1 2 Bragging, boasting
0 1 2 Concentrates or pays attention well
0 1 2 Obsessions; can't get his/her mind off of certain things
0 1 2 Restless or hyperactive
0 1 2 Clings to adults or too dependent
0 1 2 Complains of loneliness
0 1 2 Confused or seems to be in a fog
0 1 2 Cries a lot
0 1 2 Cruel to animals
0 1 2 Cruelty, bullying, or meanness to others
0 1 2 Daydreams or gets lost in his/her thoughts
0 1 2 Deliberately harms self or attempts suicide
0 1 2 Demands a lot of attention
0 1 2 Destroys his/her own things
0 1 2 Destroys things belonging to his/her family or others
0 1 2 Obedient at home
0 1 2 Obedient at school
0 1 2 Eats well
0 1 2 Gets along with other kids
0 1 2 Feels guilty over misbehaving
0 1 2 Easily jealous
0 1 2 Breaks rules at home, school, or elsewhere
0 1 2 Fears going to school
0 1 2 Fears certain animals, situations, or places (other than school)
0 1 2 Fears he/she might think or do something bad
0 1 2 Feels he/she has to be perfect
0 1 2 Feels or complains that no one loves him/her
0 1 2 Feels others are out to get him/her
0 1 2 Feels worthless or inferior
0 1 2 Gets hurt a lot or is accident prone
0 1 2 Gets in many fights
0 1 2 Gets teased a lot
0 1 2 Hangs around with others who get in trouble
0 1 2 Hears sounds or voices that aren't there
0 1 2 Impulsive or acts without thinking
0 1 2 Would rather be alone than with others
0 1 2 Lying or cheating
0 1 2 Bites fingernails
0 1 2 Nervous, high strung, or tense
0 1 2 Nervous movements or twitching
0 1 2 Nightmares
0 1 2 Liked by other kids
0 1 2 Constipated, doesn't move bowels
0 1 2 Too fearful or anxious
0 1 2 Feels dizzy or lightheaded
0 1 2 Feels too guilty
0 1 2 Overeating
0 1 2 Overtired, without good reason
0 1 2 Overweight
0 1 2 Stomachaches (without a known/medical cause)
0 1 2 Headaches (without a known/medical cause)

Continued on back of page…

0 1 2 Other aches or pains (without a known/medical cause)

0 1 2 Nausea or feeling sick (without a known/medical cause)

0 1 2 Eye problems not corrected by glasses

0 1 2 Hearing problems

0 1 2 Rashes or other skin problems (without a known/medical cause)

0 1 2 Vomiting or throwing up (without a known/medical cause)

0 1 2 Physically attacks people

0 1 2 Picks nose, skin, or other parts of body

0 1 2 Plays with own genitalia in public

0 1 2 Plays with own genitalia too much

0 1 2 Poor school work

0 1 2 Poorly coordinated or clumsy

0 1 2 Prefers being with older kids

0 1 2 Prefers being with younger kids

0 1 2 Refuses to talk

0 1 2 Repeats certain acts over and over; compulsions

0 1 2 Runs away from home

0 1 2 Screams a lot

0 1 2 Secretive or keeps things to self

0 1 2 Sees things that aren't there

0 1 2 Self-conscious or easily embarrassed

0 1 2 Sets fires

0 1 2 Sexual problems

0 1 2 Showing off or clowning around

0 1 2 Too shy or timid

0 1 2 Sleeps less than most kids

0 1 2 Sleeps more than most kids during the day

0 1 2 Sleeps more than most kids during the night

0 1 2 Poor attention or easily distracted

0 1 2 Speech problems

0 1 2 Stares blankly

0 1 2 Steals at home

0 1 2 Steals outside the home

0 1 2 Stores up too many things he/she doesn't needs; collects things unnecessarily

0 1 2 Strange behavior(s)

0 1 2 Strange ideas

0 1 2 Stubborn, sullen, or irritable

0 1 2 Sudden changes in his/her mood or feelings

0 1 2 Sulks a lot

0 1 2 Suspicious

0 1 2 Swearing or obscene language

0 1 2 Talks about killing self

0 1 2 Talks in his/her sleep

0 1 2 Walks in his/her sleep

0 1 2 Talks too much; talking seems pressured

0 1 2 Teases others a lot

0 1 2 Temper tantrums

0 1 2 Thinks about sex too much

0 1 2 Threatens people

0 1 2 Sucks his/her thumb

0 1 2 Smokes, chews or sniffs tobacco

0 1 2 Trouble sleeping

0 1 2 Truancy or skips/ditches school

0 1 2 Not active, slow moving, or lacks energy

0 1 2 Unhappy sad, or depressed

0 1 2 Unusually loud speech/talking

0 1 2 Uses illegal drugs (for non-medical purposes)

0 1 2 Vandalism or destruction of others' property

0 1 2 Wets self or has bladder accidents during the day

0 1 2 Wets the bed

0 1 2 Whining

0 1 2 Wishes to be of the opposite sex

0 1 2 Withdrawn, doesn't get involved with others

0 1 2 Worries

VII. SCHOOL INFORMATION

1. Early Intervention:

   Has your child received Early Intervention Services (e.g. Head Start, SoonerStart)?
   _____ Yes _____ No

   If yes, when? _____ How often? _____

   Services received: (Please circle all that apply)

   Speech/Language Cognitive Physical Therapy Occupational Therapy

   Other:_____

2. Schools Attended:
   Preschool / Kindergarten: _____
   Elementary School: _____
   Middle School / Jr High: _____
   High School: _____

3. Name of Present School (if different): _____ Present Grade:_____
   School's Address: _____
   City: _____ State: _____ Zip Code: _____
   School's Area Code and Phone Number: (____) _____
   Principal's Name: _____
   Primary Teacher's Name: _____

4. Previous individual school testing? _____ Yes _____ No

(IF YES, PLEASE ENCLOSE A COPY WITH THE QUESTIONNAIRE.)

5. Is there a current Individualized Education Program (IEP) in place? _____ Yes _____ No

(IF YES, PLEASE ENCLOSE A COPY WITH THE QUESTIONNAIRE.)

Dates of Testing Professional's Name Address Intervention now in progress?

_____
_____
_____
_____

6. Does your child currently receive: _____ Special Education _____ Speech Therapy
   _____ Occupational Therapy _____ Physical Therapy _____ Tutoring

7. Please describe any special education or lab classes currently attended: _____
_____

8. What are your child's current grades? ___ Above Average ___ Average ___ Below Average

9. Has there been a recent change in your child's grades? _____

   Has your child repeated any grades? _____ What grade? _____

   Is your child's work modified in any way? _____ Please explain: _____
   _____
   _____

10. What are your child's favorite subjects? _____

11. Other pertinent information about school: _____
    _____
    _____

VIII. <u>SOCIAL / EMOTIONAL DEVELOPMENT:</u>

Has your child had previous psychological or psychiatric evaluations? _____ Yes _____ No

Has your child had counseling or therapy in the past? _____ Yes _____ No

Is your child receiving therapy now? _____ Yes _____ No

Dates of Testing/Treatment Professional's Name Address Treatment now in progress?
_____
_____
_____

Please provide information regarding any concerns about your child's behavior and emotional adjustment: _____
_____
_____

Please describe the child's strengths or please note positive characteristics of your child:
_____
_____
_____

IX. <u>ADDITIONAL CONCERNS OR COMMENTS:</u>

_____
_____
_____

Parent/Guardian Signature: _____ **Date:** _____

Relationship to Child: _____