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CHILD NEUROPSYCHOLOGICAL HISTORY
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Child's Name _____ Date _____
Parent/Guardian's Name_____
Address _____
Parent/Guardian's Phone (H) _____ (W) _____(C)_____
Birthdate _____ Age _____ Gender_____ Primary Language _____
School _____ District/County_____
Grade _____ Teacher _____ Referred by _____

Medical Diagnosis (if any): (1) _____ (2) _____
(3) _____ (4) _____

Briefly describe the problem: _____
_____
What specific information would you wish as a result of this appointment?
(1) _____
(2) _____
(3) _____

Name of person completing this form: _____
Relationship to child: _____

GESTATIONAL, BIRTH AND DEVELOPMENTAL HISTORY

Biological Mother's age _____ and Father's age _____ at child's birth.
How many pregnancies preceded this one? _____ (live births_____, miscarriages _____)
Is this child adopted? _____, if so, at what age?_____.
During the pregnancy – check all that apply:

_____ poor health
_____ poor diet
_____ accident
_____ anemia
_____ bleeding
_____ diabetes
_____ illnesses
_____ preeclampsia/eclampsia
_____ psychological problems
_____ vomiting (severe/often)
_____ alcohol usage
_____ caffeine usage
_____ marijuana usage
_____ recreational drug usage
_____ tobacco usage
_____ high blood pressure
_____ infections
_____ toxemia
_____ surgery
_____ overly active fetus

Was this child born: _____ Early at _____ weeks gestation
_____ On time (38 to 42 weeks gestation)
_____ Late at _____ weeks gestation
Birth weight _____ Apgar scores: 1st _____ 2nd _____ not known_____

Check all that apply:

_____ Easy labor	_____ Demerol
_____ Difficult labor	_____ Gas
_____ Very difficult labor	_____ Spinal block
_____ Tranquilizer	_____ Epidural
_____ Forceps	_____ Caesarean section
_____ Cephalic (head first)	_____ Transverse (crosswise)
_____ Breech birth	_____ Posterior first
_____ Vacuum extraction	_____ Fetal distress
_____ Placenta previa	_____ Cord around neck
_____ Prolapsed cord	_____Other

At birth, did the baby:

_____ Have breathing difficulty	_____ Fail to cry
_____ Appear inactive	_____ Receive transfusion
_____ Receive oxygen	_____ Receive tube feedings
_____ Need incubator/isolette	_____ Have feeding difficulties

Describe any special problems, equipment needed or special care: _____
_____
How long did the baby stay in the hospital? _____

GROSS MOTOR SKILLS:	CIRCLE ONE:		
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 work sentences	Early	Average (12-24 months)	Late
SELF-HELP:			
Toilet trained	Early	Average (13-36 months)	Late

Check as many as apply to your child as an infant or toddler:

_____ weak muscle control: _____ neck _____ trunk _____ legs _____ arms

_____ unusually tight or stiff muscles	_____ poor sucking/appetite
_____ too calm and inactive	_____ banged head
_____ slept a lot more than others	_____ required little sleep
_____ had trouble getting to sleep	_____ restless sleeper
_____ rocked self to sleep	_____ unclear/late speech
_____ calm and reasonably active	_____ shy and inhibited
_____ irritable and very active	_____ colic or cried a lot
_____ neither shy nor outgoing	_____ night-time accidents
_____ very outgoing and liked people	_____ clumsy/fell a lot
_____ wore braces/corrective shoes	_____ frequent nightmares

HEALTH HISTORY

Check the following diseases or conditions that your child had:

_____ Allergies	_____ Anemia	_____ Asthma
_____ Bleeding disorder	_____ Blood disorder	_____ Brain disorder
_____ Broken bones	_____ Cancer	_____ Cerebral palsy
_____ Chicken pox	_____ Colds-excessive	_____ Diabetes
_____ Ear infections	_____ Enzyme disorder	_____ Encephalitis
_____ Genetic disorder	_____ Heart disorder	_____ Jaundice
_____ Kidney disorder	_____ Leukemia	_____ Liver disorder
_____ Lung disorder	_____ Measles	_____ Meningitis
_____ Metabolic disorder	_____ Mumps	_____ Pneumonia
_____ Oxygen deprivation	_____ Rheumatic fever	_____ Scarlet fever
_____ Tuberculosis	_____ Venereal disease	_____ Whooping cough
_____ Frequent headaches	_____ Underweight	_____ Overweight

Please note dates:

_____High fevers:_____

_____ Seizures: _____

_____ Head Injury: _____

_____ Hospitalization: _____what for?_____

List current medication(s): (on another page please note medication history if different)

MEDICATION/DOSAGE? WHEN DIAGNOSED? WHAT FOR? DATE BEGUN?

_____

_____

_____

List most recent evaluation(s):

TYPE DATE DOCTOR'S NAME

Physical _____

Vision _____

_____ Glasses: _____ Farsighted _____ Nearsighted _____ Other

Hearing _____

_____ Aid(s): _____ Left ear _____ Right ear _____ Both

What therapies have been provided for your child? Please note child's ages OR dates of therapy.

Check all that apply	Ages	Provider	Report available?
_____ Occupational therapy	_____	_____	_____
_____ Physical Therapy	_____	_____	_____
_____ Speech therapy	_____	_____	_____
_____ Counseling	_____	_____	_____
_____ Cognitive Rehabilitation	_____	_____	_____
_____ Other	_____	_____	_____

FAMILY HISTORY

Biological Mother's Name: _____
Age: _____ Level of Education: _____
Occupation: _____
Did the mother have a learning disability or other problems when she was in school? _____
Describe: _____

Biological Father's name: _____
Age: _____ Level of Education: _____
Occupation: _____
Did the father have a learning disability or other problems when he was in school? _____
Describe: _____

Please list biological brothers and sisters, step-/half-siblings, including all children in the home:

FULL NAME	AGE	GRADE/JOB	HANDEDNESS

Check if anyone in the child's biological family (including parents, grandparents, siblings, aunts & uncles) ever had:

	WHICH RELATIVE?	DESCRIBE BRIEFLY
____ Brain disease	_____	_____
____ Developmental delay	_____	_____
____ Epilepsy/Seizures	_____	_____
____ Tic/Tremors	_____	_____
____ Learning disability	_____	_____
____ Mental retardation	_____	_____
____ Neurologic disease	_____	_____
____ Psychological problems	_____	_____
____ Reading/Spelling problems	_____	_____
____ Speech/Language problems	_____	_____
____ Attention problems	_____	_____

Please note any other concerns which may have an impact on this child's current status:

List in order of frequency the languages spoken in the home (note child's first language):
(1) _____ (2) _____ (3) _____

Describe any major family stressors or changes in the past two years: _____

_____

How much have these stressors affected the child? _____

_____

Describe the discipline used with the child? _____

_____

Is the child hard to handle? _____

Are there temper tantrums? _____ How frequent? _____

Does child go to unusual lengths to attract attention? _____

Does child vary rapidly between moods? _____ Describe: _____

_____

Is child destructive? _____ Daring? _____ Cautious? _____

Does child play alone a great deal? _____ Daydream a lot? _____

Does child find it difficult to make or keep friends? _____

Does child antagonize others? _____ Is child very active? _____

Is there any fear/anxiety about separating from parent? _____

Do you consider your child depressed? _____

Does child lie or tend to storytelling? _____ Steal? _____

Describe child's usual interests, hobbies, activities: _____

_____

SCHOOL HISTORY

LEVEL GRADE(S) NAME CITY/STATE

PRESCHOOL _____

GRADE SCHOOL _____

_____

MIDDLE SCHOOL _____

_____

HIGH SCHOOL _____

_____

Did child ever repeat a grade or enter school late? _____
Describe circumstances: _____

Was child ever given special classes or services in school? _____
Describe: _____

Has child ever had a psychological evaluation? _____Please include report, if so.

PLEASE ALSO INCLUDE ALL REPORT CARDS, GROUP ACHIEVEMENT TEST RESULTS AND ANY OTHER EVALUATION REPORTS OR ACCOMMODATION PLANS.

PLEASE DESCRIBE CURRENT PATTERNS IN THE FOLLOWING AREAS:
(Please note if changes/problems occurred previously)
EATING:

SLEEPING:

ELIMINATION:

PLEASE NOTE DATES AND CIRCUMSTANCES OF MARITAL SEPARATION, DIVORCE, RE-MARRIAGE:

SYMPTOM SURVEY

For each symptom that applies to the child, place a check on the line. Compare the child to other children of the same age. Then, 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.

1) **PROBLEM SOLVING**

CHECK	NEW	OLD	
_____	___	___	Difficulty figuring out how to do new things
_____	___	___	Difficulty making decisions
_____	___	___	Difficulty planning ahead
_____	___	___	Difficulty solving problems a younger child can do
_____	___	___	Disorganized in his/her approach to problems
_____	___	___	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 on activity to another activity
_____	___	___	Easily frustrated
_____	___	___	Other problem solving difficulties: _____

2) **SPEECH, LANGUAGE AND MATH SKILLS**

CHECK	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 letter or words
_____	___	___	Difficulty reading letters or words
_____	___	___	Difficulty with spelling
_____	___	___	Difficulty with math
_____	___	___	Other speech, language, or math problems: _____

3) **SPATIAL SKILLS**

CHECK	NEW	OLD	
_____	___	___	Confusion telling right from left
_____	___	___	Has difficulty with puzzles, Legos, blocks, or similar games
_____	___	___	Problems drawing or copying
_____	___	___	Does not 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: _____

4) **AWARENESS AND CONCENTRATION**

CHECK	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 or other electronics for long periods of time
_____	___	___	Attention starts out OK but can't keep it up
_____	___	___	Other attention or concentration problems: _____

5) **MEMORY**

CHECK	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: _____

6) **MOTOR AND COORDINATION**

CHECK	NEW	OLD		Check the side this occurs on: Right side	Left side	Both sides
_____	___	___	Poor fine motor skills (e.g. using 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: _____			

7) **SENSORY**

CHECK	NEW	OLD		Check the side this occurs on: Right side	Left side	Both sides
_____	___	___	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: _____			

8) **PHYSICAL**

CHECK	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: _____	

9) **BEHAVIOR**

CHECK	NEW	OLD		CHECK	NEW	OLD	
_____	___	___	Aggressive	_____	___	___	Nervous
_____	___	___	Attached to things, not people	_____	___	___	Nightmares, night terrors, sleepwalks
_____	___	___	Bed wetting	_____	___	___	Quiet
_____	___	___	Bizarre behavior	_____	___	___	Resists change
_____	___	___	Bowel movements in underwear	_____	___	___	Risk-taking
_____	___	___	Dependent	_____	___	___	Self-mutilates
_____	___	___	Depressed	_____	___	___	Shy and withdrawn
_____	___	___	Eating habits are poor	_____	___	___	Sleeping habits are poor
_____	___	___	Emotional	_____	___	___	Swears a lot
_____	___	___	Fearful	_____	___	___	Unmotivated
_____	___	___	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
____ Can't remain seated
____ Highly distractible
____ Can't wait for his/her turn when playing with others
____ Answers before he/she hears the whole question
____ Rarely follows others' instructions
____ Has a hard time concentrating for long periods
____ Goes from one activity to another without finishing anything
____ Frequently makes noise when playing
____ Seems like he/she is always talking
____ Is often rude or interrupts others
____ Doesn't listen to other people
____ Seems like he/she frequently is losing things that are needed at school
____ Frequently does dangerous things without considering the consequences

___ Steals things without people knowing on several occasions
___Often runs away from parents' home and stays away overnight
___ Easily lies to others
___ Fire setting
___ Doesn't go to school
___ Breaks into other people's property
___ Destroys other people's property in some manner, other than by fire
___ Is cruel to animals
___ Has forcible sexual relations with others
___When fighting, has used a weapon on more than one occasion
___ Starts fights with others
___Will steal directly from people
___ Is cruel to other people

10) Overall, t he child's symptoms have developed: _____ Slowly _____ Quickly

11) The symptoms occur: _____ Occasionally _____ Often

12) Over the past 6 months the symptoms have: _____ Stayed about the same _____ Worsened