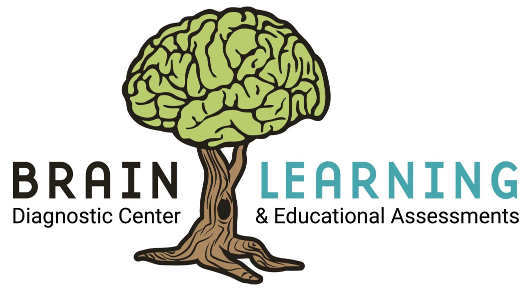

CHILD AND ADOLESCENT NEUROPSYCHOLOGY HISTORY FORM

GENERAL CLIENT INFORMATION					
Name of Client		Date of Birth		Age	
Home Address		Gender	☐ Male ☐ Female		
City, State and Zip		Home Phone			
School Name		Grade			
School Address		School Contact			
City, State and Zip		School Phone			
Teacher's Name		Teacher's Email			

Child lives with (please check all that apply)

☐ Natural Mother ☐ Natural Father ☐ Stepmother ☐ Stepfather ☐ Adoptive Mother

☐ Adoptive Father ☐ Other____________________

REFERRAL INFORMATION
Please state the reason for this referral:
Please list specific questions that you would like Brain Learning to answer about you child.
1.
2.
3.

LANGUAGE INFORMATION	
What language(s) is/are spoken at home:	
What language are <u>you</u> most comfortable with to receive information?	
What language are <u>your child</u> most comfortable with to receive information?	

PREGNANCY AND BIRTH HISTORY				
Age of mother at time of delivery:		Age of father at time of delivery:		
Is this child adopted?				☐ Yes ☐ No
Was this child a planned pregnancy?				☐ Yes ☐ No
Was the mother under a physician care during her pregnancy?				☐ Yes ☐ No
Number of previous pregnancies.				
Number of previous miscarriages.				
Was this child born in a hospital?				☐ Yes ☐ No
If no, where was your child born?				

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Check any of the following complications that occurred during the pregnancy.

- [ ] Flu
- [ ] Vaginal bleeding
- [ ] Excessive Swelling
- [ ] Blood loss or staining
- [ ] RH Incompatibility
- [ ] Anemia
- [ ] Excessive vomiting
- [ ] Threatened Miscarriage
- [ ] High blood pressure
- [ ] Toxemia
- [ ] Emotional problems
- [ ] German Measles
- [ ] Difficulty in conception
- [ ] High blood sugar/diabetes
- [ ] Abnormal weight gain

Other illness or problems during pregnancy:

Medications or medical treatment required during pregnancy (what kind)?

Was alcohol, drugs or tobacco products used during pregnancy (if so, describe)

Length of pregnancy:		Child's birth weight: ________ lbs. _______ oz.	Apgar Score: ____________
Childs condition at birth:			
Mothers condition at birth:			

Check any of the following complications that occurred during birth.

- [ ] Caesarean Delivery
- [ ] Induced Delivery
- [ ] Forceps Used
- [ ] Cord around the neck
- [ ] Hemorrhage
- [ ] Breathing problems
- [ ] Breach birth
- [ ] Yellow in color (jaundice)
- [ ] Injury to baby
- [ ] Blue in color
- [ ] Fetal Distress

Other delivery complications:

After birth did your child stay in the regular nursery or did he/she go to the intensive care nursery? ☐ Regular Nursery ☐ Intensive Care

At birth, my child received (check all that apply and for how long)

☐ Supplemental Oxygen		☐ Phototherapy (lights)		☐ Resuscitation (if yes, describe)
☐ Respirator		☐ Transfusions		

Other complications while the baby was still in the hospital.

Length of stay in the hospital for	Mother:	Child:

DEVELOPMENTAL HISTORY

Please indicate the age at which your child did the following:

Roll Over		Sit alone		Crawl	
Stand alone		Walk alone		Walk up stairs	
Walk down stairs		Ride a tricycle		Ride a bicycle without training wheels	
First words		Two-word phrases		Sentences	
Tie shoe laces		Toilet trained		Button and zipper clothes	

Was this child breast fed?	☐ Yes ☐ No	When weaned?	
Was this child bottle fed?	☐ Yes ☐ No	When weaned?	
When was this child toilet trained?	Days:	Nights:	
Did bed wetting occur after toilet training?	☐ Yes ☐ No	If yes, until what age?	
Did bed soiling occur after toilet training?	☐ Yes ☐ No	If yes, until what age?	

Were there any medical reasons for bed wetting or soiling? (if yes, describe) ☐ Yes ☐ No

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Has your child experienced any of the following problems? If so please describe.	
Walking difficulty:	☐ Yes ☐ No
Unclear speech:	☐ Yes ☐ No
Feeding:	☐ Yes ☐ No
Underweight:	☐ Yes ☐ No
Overweight:	☐ Yes ☐ No
Colic:	☐ Yes ☐ No
Sleep:	☐ Yes ☐ No
Eating:	☐ Yes ☐ No
Difficulty learning to ride a bike:	☐ Yes ☐ No
Difficulty learning to throw or catch:	☐ Yes ☐ No

During the child's first 5 years, were there any special problems noted in the following areas? If yes please describe.	
Eating:	☐ Yes ☐ No
Motor skills:	☐ Yes ☐ No
Sleeping to much:	☐ Yes ☐ No
Temper tantrums:	☐ Yes ☐ No
Sleeping to little:	☐ Yes ☐ No
Failure to thrive:	☐ Yes ☐ No
Separation from parents:	☐ Yes ☐ No
Excessive crying:	☐ Yes ☐ No

Question	Answer
Which hand does your child use for writing or drawing?	☐ Right Hand ☐ Left Hand ☐ Either/No Preference
Which hand does your child use for eating?	☐ Right Hand ☐ Left Hand ☐ Either/No Preference
Which hand does your child use for other things (throwing, etc.)?	☐ Right Hand ☐ Left Hand ☐ Either/No Preference
Has your child been forced to change writing hand?	☐ Yes ☐ No

Does your child have any difficulty performing **age appropriate** activities listed below? (please check all that apply)

☐ Walking	☐ Sitting	☐ Running	☐ Climbing Stairs	☐ Social Interaction	☐ Communicating	☐ Toileting
☐ Dressing	☐ Reaching	☐ Bathing	☐ Using Utensils	☐ Feeding Themselves	☐ Sleeping	

MEDICAL HISTORY

Please indicate age (year/month)

Childhood Illness/Injuries	Age	Childhood Illness/Injuries	Age	Childhood Illness/Injuries	Age
Measles		Rheumatic Fever		Mumps	
German Measles		Diphtheria		Meningitis	
Chicken Pox		Encephalitis		Tuberculous	
Anemia		Whooping Cough		Fever above 104	
Scarlet Fever		Broken Bones		Sustained High Fever	
Pneumonia		Tonsils/adenoids removed?		Stitches	

Question	Answer
Has your child been involved in any serious accidents?	☐ Yes ☐ No

If yes please list age and type of accident:

Question	Answer
Has your child ever had a head injury requiring medical attention?	☐ Yes ☐ No
If yes, was there loss of consciousness (blackout)?	☐ Yes ☐ No

What tests or procedures were performed?

At what age did this occur?

Question	Answer
Did you notice any longstanding problems after the injury?	☐ Yes ☐ No

If yes please describe:

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Please describe other serious illnesses or operations as well the age of the child at the time.		
Please indicate whether this child currently has any of the following and if so please describe how often.		
Frequent colds:		☐ Yes ☐ No
Chronic cough:		☐ Yes ☐ No
Asthma:		☐ Yes ☐ No
Allergies:		☐ Yes ☐ No
Heart murmur:		☐ Yes ☐ No
Excessive vomiting:		☐ Yes ☐ No
Frequent diarrhea:		☐ Yes ☐ No
Constipation:		☐ Yes ☐ No
Pain while urinating:		☐ Yes ☐ No
Excessive urination:		☐ Yes ☐ No
Strong odor to urine:		☐ Yes ☐ No
Muscle pain:		☐ Yes ☐ No
When?	Where?	
Clumsy walk:		☐ Yes ☐ No
Poor posture:		☐ Yes ☐ No
Other muscle problems:		☐ Yes ☐ No
Frequent rashes:		☐ Yes ☐ No
Bruises easily:		☐ Yes ☐ No
Severe Acne:		☐ Yes ☐ No
Itchy skin (Eczema)		☐ Yes ☐ No
Seizures/Convulsions:		☐ Yes ☐ No
If your child has had seizures/convulsions please list details (onset, type, how many, most recent)		
Speech defects:		☐ Yes ☐ No
Accident prone:		☐ Yes ☐ No
Bites nails:		☐ Yes ☐ No
Sucks thumb:		☐ Yes ☐ No
Grinds teeth:		☐ Yes ☐ No
Has tics/twitches:		☐ Yes ☐ No
Bangs head:		☐ Yes ☐ No
Rocks back and forth:		☐ Yes ☐ No
Has this child taken any medication to increase activity?		☐ Yes ☐ No
When?	What medication?	
Has this child taken any tranquilizing medications?		☐ Yes ☐ No
When?	What medication?	
Has this child taken any medication for ADD, ADHD or similar problems?		☐ Yes ☐ No
When?	What medication?	

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Allergies:	☐ Yes ☐ No
Stuttering:	☐ Yes ☐ No
Unclear speech:	☐ Yes ☐ No
Other speech problems:	☐ Yes ☐ No
Date of most recent speech exam:	
Ear infections	☐ Yes ☐ No
Hearing problems:	☐ Yes ☐ No
Ear tubes:	☐ Yes ☐ No
Date of most recent hearing exam:	
Vision problems:	☐ Yes ☐ No
Wears glasses or contacts:	☐ Yes ☐ No
Date of most recent vision exam:	

Child's Primary Care Physician Name:		Phone Number:	
How often does this child see this doctor?		Date of last visit	

Please list all professionals that currently or have previously worked with your child outside of school.

Type of Professional	Name of professional	Dates	Duration	Reason and Outcome
Neurosurgeon				
Neurologist				
Ear, Nose & Throat				
Physical Therapist				
Psychologist				
Psychiatrist				
Occupational Therapist				
ABA Therapist				
Other				

Is this child on medication? (If yes, please indicate type, dosage, and reasoning) ☐ Yes ☐ No

Medication	Dosage	Reason for taking the medication

Has your child ever had any negative reactions to medications (behavioral or physiological)? ☐ Yes ☐ No

If yes please describe:

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List all the diagnoses your child has received:		
Diagnosis	Age of child at diagnosis	Name/Title of person who diagnosed your child

Please answer the following questions about this child:	
How is your child's hearing?	☐ Good ☐ Fair ☐ Poor
How is your child's vision?	☐ Good ☐ Fair ☐ Poor
How are your child's current gross motor skills?	☐ Good ☐ Fair ☐ Poor
How are your child's current fine motor skills?	☐ Good ☐ Fair ☐ Poor
How is your child's speech articulation?	☐ Good ☐ Fair ☐ Poor
Is there any suspicion of alcohol or drug use?	☐ Yes ☐ No
Is there any history of sexual abuse?	☐ Yes ☐ No
If yes, explain:	

Describe other medical conditions and or problems not listed above.

PSYCHOLOGICAL TREATMENT HISTORY

Has your child ever had any of the following forms of psychological treatment?	
Type of treatment	Duration
Individual psychotherapy	
Group psychotherapy	
Family therapy with child	
Inpatient evaluation/Rx	
Residential treatment	

Please list the start date and current frequency for the following (if applicable):			
Therapy	Frequency	Start Date	End Date
Physical Therapy			
Occupational Therapy			
Speech Therapy			
Counseling			

FAMILY HISTORY

Parents' marital status:

☐ Married ☐ Separated ☐ Divorced ☐ Living Together

☐ Other:

If parents are separated or divorced who has physical custody of this child?	☐ Mother ☐ Father ☐ Both
If parents are separated or divorced who has legal custody of this child?	☐ Mother ☐ Father ☐ Both

How often does the other parent see this child?

☐ Weekly or more often ☐ Few times a year ☐ Once or twice a month ☐ Never

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Is this child closer to one parent than the other? (If yes, which)	☐ Yes ☐ No
Has this child ever experienced any parental separations, divorces, or death?	☐ Yes ☐ No
If yes, when?	how old was your child?
Please describe the circumstances.	

Parent 1 Name	Relationship (mother, father, guardian):	Phone Number:
Occupation:	Hobbies:	Highest grade completed:
Primary Language:	Secondary Language:	

Personal History (please check all that apply)

☐ Headaches	☐ Depression	☐ Difficulty with math	☐ Speech problems in childhood
☐ Seizures	☐ Anxiety	☐ Spelling difficulty	☐ Reading problems
	☐ Bipolar disorder	☐ Learning problems	☐ Attention problems

Other medical conditions:

Please describe present health:

Parent 2 Name	Relationship (mother, father, guardian):	Phone Number:
Occupation:	Hobbies:	Highest grade completed:
Primary Language:	Secondary Language:	

Personal History (please check all that apply)

☐ Headaches	☐ Depression	☐ Difficulty with math	☐ Speech problems in childhood
☐ Seizures	☐ Anxiety	☐ Spelling difficulty	☐ Reading problems
	☐ Bipolar disorder	☐ Learning problems	☐ Attention problems

Other medical conditions:

Please describe present health:

FAMILY HEALTH HISTORY

Has any family member had any of the following? If yes, please specify family member's relationship to this child, Side of the family and any details if known. (check M for mother F for father)

Condition	Relative(s)	Side of Family	Describe:
Alcohol/Drug Abuse		☐ M ☐ F	
Alzheimer's Disease		☐ M ☐ F	
Attention Deficit/ Hyperactivity		☐ M ☐ F	
Behavior Disorder		☐ M ☐ F	
Birth Defects		☐ M ☐ F	
Brain or Neurologic Disease		☐ M ☐ F	
Cancer		☐ M ☐ F	
Cerebral Palsy		☐ M ☐ F	
Developmental Delay		☐ M ☐ F	

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Diabetes		☐ M ☐ F	
Emotional Disturbance		☐ M ☐ F	
Epilepsy or Seizures		☐ M ☐ F	
Food Allergies		☐ M ☐ F	
Genetic Disorder		☐ M ☐ F	
Heart Disease		☐ M ☐ F	
High Blood Pressure		☐ M ☐ F	
Intellectual Disability (or Mental Retardation)		☐ M ☐ F	
Learning Disability		☐ M ☐ F	
Mental Illness		☐ M ☐ F	
Migraine Headaches		☐ M ☐ F	
Nervousness		☐ M ☐ F	
Other Learning Disability		☐ M ☐ F	
Physical Handicap		☐ M ☐ F	
Psychiatric Disorder		☐ M ☐ F	
Reading Problems		☐ M ☐ F	
Seizures or Epilepsy		☐ M ☐ F	
Severe Head Injury		☐ M ☐ F	
Sickle-Cell Anemia		☐ M ☐ F	
Speech or Language Disorder		☐ M ☐ F	
Stroke		☐ M ☐ F	
Tourette's Syndrome		☐ M ☐ F	
Other:		☐ M ☐ F	

Has anyone in the family ever been in special education (If yes, who and what type of class)?

FAMILY/SOCIAL HISTORY

Please list all adults living with this child:

Please list below all brothers, sisters or any other children living with the family.

Relationship	Gender	Age	Living at home?
	☐ Male ☐ Female		☐ Yes ☐ No
	☐ Male ☐ Female		☐ Yes ☐ No
	☐ Male ☐ Female		☐ Yes ☐ No
	☐ Male ☐ Female		☐ Yes ☐ No
	☐ Male ☐ Female		☐ Yes ☐ No

How does this child get along with his/her brother(s) and/or sister(s)?

Does anyone in the household(s) smoke? ☐ Yes ☐ No

Who is the primary caretaker(s) for your child?

Check all activities in which this child often participates with the family

☐ Movies ☐ Meals ☐ Conversations ☐ Visits with relatives ☐ Church ☐ Games ☐ Sports

☐ Trips ☐ Television ☐ Other______________________________

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How frequently does this child see his grandparents?
☐ Weekly or more often ☐ Once or twice a month ☐ Few times a year ☐ Never ☐ No grandparents living
What are your child's strengths?
What are your child's challenges?
Does your child have career interests? If so, please describe.
What level of education do you hope your child will complete? (check one)
☐ High School ☐ Technical or Vocational School ☐ College ☐ Law, Medical, Other Advanced Studies
Who is mainly in charge of discipline in the home?
To what extent are you and your spouse consistent with respect to disciplinary strategies?
☐ Most of the time ☐ Some of the time ☐ None of the time
What discipline techniques do you use?
☐ Verbal reprimands ☐ Time out (isolation) ☐ Acquiescence to child ☐ Removal of privileges ☐ Rewards ☐ Avoidance of child ☐ Physical punishment ☐ Other: ___
Have any of the following "stress events" occurred within the past 12 months?
☐ Parents divorced/separated ☐ Family accident/illness ☐ Change Schools ☐ Parent changed job ☐ Family financial problems ☐ Death in the family ☐ Family moved ☐ Other:
Does your child require any type of assistance?
☐ Bath chair ☐ Stander ☐ Cane ☐ Specialized stroller ☐ Wheelchair ☐ Crutches ☐ Walker ☐ Hearing Aid ☐ Manual or ☐ Power ☐ Other:

FRIENDSHIPS/RECREATION

Please indicate how this child relates to other children.	
Has problems relating to or playing with other children?	☐ Yes ☐ No
Fights frequently with playmates?	☐ Yes ☐ No
Prefers playing with younger children?	☐ Yes ☐ No
Has difficulty making friends?	☐ Yes ☐ No
Prefers to play alone?	☐ Yes ☐ No
What role does this child take in peer group games (e.g. leader, follower, etc.)?	
What activities does this child enjoy?	
☐ Clubs:	
☐ Sports:	
☐ Other:	
What are your child's interests or hobbies?	
Has this child's interest in participating in these activities declined recently?	☐ Yes ☐ No
If yes, describe:	

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BEHAVIOR/TEMPERMENT

Please indicate whether this child exhibits any of the following behaviors:

Behavior	Response
Is easily overstimulated in play?	☐ Yes ☐ No
Has a short attention span?	☐ Yes ☐ No
Seems overly energetic in play?	☐ Yes ☐ No
Seems impulsive?	☐ Yes ☐ No
Lacks self-control?	☐ Yes ☐ No
Overreacts when faced with a problem?	☐ Yes ☐ No
Seems unhappy most of the time?	☐ Yes ☐ No
Seems uncomfortable meeting new people?	☐ Yes ☐ No
Withholds affection?	☐ Yes ☐ No
Requires a lot of parental attention?	☐ Yes ☐ No
Hides feelings?	☐ Yes ☐ No
Cannot calm down?	☐ Yes ☐ No
Has fears?	☐ Yes ☐ No

If yes, describe:

What makes this child angry?

EDUCATIONAL HISTORY

Please summarize your child's progress (e.g. academic, social, and testing) within each of these grade levels:

Grade	School	IEP/Section 504	Interventions/concerns: e.g., technology, accommodations
Preschool			
Kindergarten			
Grade 1			
Grade 2			
Grade 3			
Grade 4			
Grade 5			
Grade 6			
Grade 7			
Grade 8			
Grade 9			
Grade 10			
Grade 11			
Grade 12			

Grade in which school difficulty first arose?

Preschool/Daycare

Does or did this child attend preschool/daycare? ☐ Yes ☐ No

If yes at what age, amount of time per day, and days per week?

Any problems in preschool? ☐ Yes ☐ No

If yes, describe:

Does or did this child attend kindergarten? ☐ Yes ☐ No

If yes, describe:

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Elementary School	
Please indicate whether this child has had any of the following school experiences.	
Has your child changed schools for reasons other than normal academic progression?	☐ Yes ☐ No
If yes, when and why?	
Has your child ever been retained a grade in school?	☐ Yes ☐ No
If yes, when and why?	
Has your child ever skipped a grade in school?	☐ Yes ☐ No
If yes, when and why?	
Does your child have difficulty with reading?	☐ Yes ☐ No
If yes, describe:	
Does your child have difficulty with reading, writing and/or math?	☐ Yes ☐ No
If yes, describe:	
Does your child get poor grades?	☐ Yes ☐ No
If yes, describe most recent report card results:	
Has your child been tested for special education?	☐ Yes ☐ No
If yes, when was your child tested?	

Does your child have a 504 plan in place?	☐ Yes ☐ No	Does your child have an IEP?	☐ Yes ☐ No

Programs or classes in place

☐ Resource Program ☐ Behavioral/Emotional Disorders Class ☐ Special Day Class

☐ Other (please specify): ____________________

Does your child receive any related services in school? (please check all that apply)

☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐ Counseling ☐ Assistive Technology

☐ Other____________________

Have any additional instructional modifications been attempted?

☐ None ☐ Behavior modification program ☐ Daily/Weekly report card

☐ Other (specify): ____________________

Has your child ever been suspended from school?	☐ Yes ☐ No	Number of suspensions?	
Has your child ever been expelled from school?	☐ Yes ☐ No	Number of expulsions?	

Does your child dislike going to school?	☐ Yes ☐ No
If yes, why?	
Has your child been absent from school frequently?	☐ Yes ☐ No
If yes, why?	
If your child is in high school, when will he/she graduate?	/20
Do you have any concerns about the quality of this child's school teachers?	☐ Yes ☐ No
If yes, describe:	

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Is there anything that was not on this form that we should be aware of?	
Printed name of person completing this form:	Relationship to child:
Parent Signature:	Date:

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