

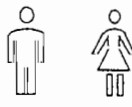

CHILD NEUROPSYCHOLOGICAL HISTORY

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Patient Information

Child's name		Today's date	
Street			
City		State	Zip
Parent or Guardian's Telephone: Day ()		Eves. ()	

Child's Social Security No.	Office use only:
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Age	Birthdate / /	 <p>Circle the child's Gender</p>	 <p>Circle the hand currently used for writing <input type="checkbox"/> This hand preference is new</p>
Primary Language			
Ethnicity or Race			
Religion			
Diagnosis #1			
Diagnosis #2			

Grade	School Name	School District
If in a special class or program describe it:		
Type of School: <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Parochial <input type="checkbox"/> Other:		

Referral Information

Who referred the child?	Dr. Mr. Ms.
From (Institution or Affiliation)	
Why was the child referred?	
What specific questions would you like answered by this evaluation?	1
	2
	3

Respondent Information

Your name	Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other:
Street	
City	State Zip
Day telephone	Evening telephone

PROBLEM CHECKLIST

Report all problems that apply by checking the OLD or NEW problem box (complete the table below to indicate how you will use the OLD and NEW descriptions). Then rate the severity of any checked problem from 1 to 5 using the scale in each section. Compare the child to children of the same age. If a problem does not apply or you are unsure, leave the box blank.

OLD Check one box to indicate how you will use the OLD description <input type="checkbox"/> The problem existed before a recent illness or injury <input type="checkbox"/> The problem began more than 1 year ago	NEW Check one box to indicate how you will use the NEW description <input type="checkbox"/> The problem began after a recent illness or injury <input type="checkbox"/> The problem began within the past year
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1 PROBLEM SOLVING			1 = Mild 2 = Mild to Moderate 3 = Moderate 4 = Moderate to Severe 5 = Severe
OLD	NEW	Rate	
<input type="checkbox"/>	<input type="checkbox"/>		Child has difficulty...
<input type="checkbox"/>	<input type="checkbox"/>		learning new or complex activities or concepts
<input type="checkbox"/>	<input type="checkbox"/>		with organizing activities, schoolwork, or personal items at home
<input type="checkbox"/>	<input type="checkbox"/>		solving problems a younger child can do
<input type="checkbox"/>	<input type="checkbox"/>		understanding explanations
<input type="checkbox"/>	<input type="checkbox"/>		benefiting from experience (makes the same error repeatedly)
<input type="checkbox"/>	<input type="checkbox"/>		varying play/recreation activities, or varying problem solving strategies (inflexibility)
<input type="checkbox"/>	<input type="checkbox"/>		switching from one activity to another activity (transitions)
<input type="checkbox"/>	<input type="checkbox"/>		completing an activity in a reasonable period of time, or understanding time constraints
<input type="checkbox"/>	<input type="checkbox"/>		Quickly frustrated and gives up easily
<input type="checkbox"/>	<input type="checkbox"/>		Other problem solving difficulties:
In new situations, the child tends to learn by: <input type="checkbox"/> talking a lot <input type="checkbox"/> listening and observing <input type="checkbox"/> touching/handling			

2 LANGUAGE			1 = Mild 2 = Mild to Moderate 3 = Moderate 4 = Moderate to Severe 5 = Severe
OLD	NEW	Rate	
<input type="checkbox"/>	<input type="checkbox"/>		Articulation: <input type="checkbox"/> omits sounds <input type="checkbox"/> substitutes sounds <input type="checkbox"/> distorts sounds <input type="checkbox"/> mixes sequence (aminal)
<input type="checkbox"/>	<input type="checkbox"/>		Fluency: <input type="checkbox"/> difficulty finding the right word to say <input type="checkbox"/> limited amount of speech <input type="checkbox"/> slow, labored speech
<input type="checkbox"/>	<input type="checkbox"/>		Speaks in a monotone (very little emotion in speech)
<input type="checkbox"/>	<input type="checkbox"/>		Talks much more than average and in an unusual way
<input type="checkbox"/>	<input type="checkbox"/>		Odd or unusual language or vocal sounds
<input type="checkbox"/>	<input type="checkbox"/>		Difficulty understanding what others are saying
<input type="checkbox"/>	<input type="checkbox"/>		Other speech or language problems:
The child's best language skill is:			

3 SCHOOL SKILLS				Rate each skill compared to children the same age
POOR	AVERAGE	GOOD		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Reading letters or words
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Reading comprehension
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Writing letters (correct form, proper orientation)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Written expression (forming ideas, organization, grammar, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Spelling
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Math Difficulty with: <input type="checkbox"/> written math <input type="checkbox"/> mental calculations <input type="checkbox"/> word problems
<input type="checkbox"/> Needs more time than other children to complete schoolwork				
<input type="checkbox"/> Difficulty with homework:				
<input type="checkbox"/> Other school problems:				
Difficulty with school seemed to begin (age or grade):				

4 NONVERBAL SKILLS		1 = Mild	2 = Mild to Moderate	3 = Moderate	4 = Moderate to Severe	5 = Severe
OLD	NEW	Rate				
<input type="checkbox"/>	<input type="checkbox"/>		Difficulty with puzzles, Legos®, blocks, or similar games			
<input type="checkbox"/>	<input type="checkbox"/>		Confusion with direction (right/left) or orientation (back/front or up/down)			
<input type="checkbox"/>	<input type="checkbox"/>		Problems drawing or copying			
<input type="checkbox"/>	<input type="checkbox"/>		Does not reliably identify colors <input type="checkbox"/> is color blind			
<input type="checkbox"/>	<input type="checkbox"/>		Difficulty recognizing objects or people child should know			
<input type="checkbox"/>	<input type="checkbox"/>		Difficulty with dressing (tying shoes, pulling up zipper) that is not due to a physical disability			
<input type="checkbox"/>	<input type="checkbox"/>		Other nonverbal problems:			
Child is much better with: <input type="checkbox"/> language than hands-on activities <input type="checkbox"/> hands-on activities than language						

5 ATTENTION		1 = Mild	2 = Mild to Moderate	3 = Moderate	4 = Moderate to Severe	5 = Severe
OLD	NEW	Rate				
<input type="checkbox"/>	<input type="checkbox"/>		Mind appears to go blank at times, or loses train of thought			
<input type="checkbox"/>	<input type="checkbox"/>		Difficulty paying attention: <input type="checkbox"/> in class <input type="checkbox"/> at home <input type="checkbox"/> with other children			
Problems with attention seemed to start around age: _____						
<input type="checkbox"/> Attentional problems improve with some activities (e.g., better with TV or video games than when required to listen)						
The child seems: <input type="checkbox"/> inattentive and hyperactive <input type="checkbox"/> inattentive but not hyperactive						
The child concentrates best when: _____						

6 MEMORY & LEARNING		1 = Mild	2 = Mild to Moderate	3 = Moderate	4 = Moderate to Severe	5 = Severe
OLD	NEW	Rate				
<input type="checkbox"/>	<input type="checkbox"/>		Frequently forgets...			
<input type="checkbox"/>	<input type="checkbox"/>		where s/he leaves toys, schoolwork, or other objects			
<input type="checkbox"/>	<input type="checkbox"/>		what happened recently (e.g., prior meal)			
<input type="checkbox"/>	<input type="checkbox"/>		what happened days/weeks ago			
<input type="checkbox"/>	<input type="checkbox"/>		school assignments			
<input type="checkbox"/>	<input type="checkbox"/>		what s/he has been told recently			
<input type="checkbox"/>	<input type="checkbox"/>		Other memory or learning problems:			
<input type="checkbox"/> Can recognize something even if s/he cannot recall it						
Since a recent accident, child has difficulty: <input type="checkbox"/> recalling events before the accident <input type="checkbox"/> recalling new events						
The child is best at remembering: _____						

7 MOTOR & COORDINATION		1 = Mild	2 = Mild to Moderate	3 = Moderate	4 = Moderate to Severe	5 = Severe
OLD	NEW	Rate			Left side	Right side
<input type="checkbox"/>	<input type="checkbox"/>		Muscle weakness or paralysis . . .		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Muscle tightness or spasticity . . .		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Clumsy or awkward . . .		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Walking (gait) problems . . .		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Odd movements (posturing, peculiar hand movements, etc.)			
<input type="checkbox"/>	<input type="checkbox"/>		Involuntary or repetitive movements:		<input type="checkbox"/> eye/facial	<input type="checkbox"/> vocal
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> limbs	<input type="checkbox"/> body
<input type="checkbox"/>	<input type="checkbox"/>		Oral (mouth) motor problems			
<input type="checkbox"/>	<input type="checkbox"/>		Poor fine motor skills (e.g., using a pencil, scissors, etc.)			
<input type="checkbox"/>	<input type="checkbox"/>		Other motor or coordination problems:			

8 SENSORY			1 = Mild	2 = Mild to Moderate	3 = Moderate	4 = Moderate to Severe	5 = Severe	
OLD	NEW	Rate					Left side	Right side
<input type="checkbox"/>	<input type="checkbox"/>		Vision problems . . .				<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Hearing problems . . .				<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Loss of feeling on skin . . .				<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		Difficulty smelling or tasting foods					
<input type="checkbox"/>	<input type="checkbox"/>		Overly sensitive to: <input type="checkbox"/> touch <input type="checkbox"/> light <input type="checkbox"/> noise					
<input type="checkbox"/>	<input type="checkbox"/>		Other sensory problems:					

9 BEHAVIOR			1 = Mild	2 = Mild to Moderate	3 = Moderate	4 = Moderate to Severe	5 = Severe
OLD	NEW	Rate	OLD	NEW	Rate		
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		Bedwetting	
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		Bizarre or unusual behavior	
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		Dependent for age	
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		Depressed	
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		Eating habits are poor or unusual	
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		Emotional	
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		Fearful or nervous	
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		Immature for age	
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		Impulsive or disinhibited	
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		Repetitive behaviors	
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		Risky (dangerous) behaviors	
						Self-esteem is low	
						Self-mutilates or stimulates	
						Sexual behavior is inappropriate	
						Sleeping problems	
						Social skills are poor	
						Suicidal acts or statements	
						Unemotional	
						Uninterested in people	
						Unusual beliefs	
						Withdrawn (solitary) play	
						Other:	
<input type="checkbox"/> Aggressive to people or animals <input type="checkbox"/> Destructive <input type="checkbox"/> Firesetting <input type="checkbox"/> Steals <input type="checkbox"/> Ignores rules/rebellious <input type="checkbox"/> Angry							
<input type="checkbox"/> The child's behavior is very different depending on the situation:							
<input type="checkbox"/> The child's behavior has recently changed:							

Check behaviors that occur more frequently than in children of the same age and that have been present for at least the past 6 months

Mild	Moderate	Severe	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inattentive to details or makes careless mistakes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sustaining attention over time in schoolwork or play
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does not seem to listen when spoken to
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does not follow through on instructions and fails to complete schoolwork or other activities
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty organizing activities
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoids or dislikes activities that require a lot of mental effort (schoolwork, homework)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loses things necessary for tasks at home or school
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily distracted: Distracted by <input type="checkbox"/> sounds <input type="checkbox"/> sights <input type="checkbox"/> physical sensations
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Very forgetful
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fidgety, restless when seated
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leaves seat in classroom or other situations when required to remain seated
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runs or climbs when it is inappropriate to do so, or feels very restless
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty playing quietly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Always moving or acts as if driven by a motor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Talks excessively
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurts out answers before questions are completed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty awaiting turn in class or in games
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interrupts or intrudes frequently

10 Overall, most of the problems developed gradually <- in-between -> quickly

11 Most problems occur occasionally <- in-between -> often

12 Compared to brothers/sisters, child has: few problems similar problems more problems

Compared to other children of the same age, child has: . few problems similar problems more problems

PREGNANCY

Pregnancy information is unknown

13 How often did the biological mother see the doctor during her pregnancy with this child?

- As scheduled by the doctor
 Rarely
 Not at all
 Mother initially was unaware of this pregnancy for a long time

14 List all medications (prescribed and over-the-counter) the mother took. Use an additional page if needed.

1 - 2 months <i>before</i> this pregnancy	<input type="checkbox"/> None	<i>During</i> this pregnancy	<input type="checkbox"/> None
1		1	
2		2	
3		3	

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

<input type="checkbox"/> None of the below	Describe pattern of use
<input type="checkbox"/> Alcohol	
<input type="checkbox"/> Caffeine (coffee, tea, etc.)	
<input type="checkbox"/> Recreational drugs (marijuana, cocaine, etc.)	
<input type="checkbox"/> Tobacco	
<input type="checkbox"/> Other drugs (describe)	

16 During the pregnancy, the mother's...

	Good	Poor	If poor, explain
diet was:	<input type="checkbox"/>	<input type="checkbox"/>	
physical health was:	<input type="checkbox"/>	<input type="checkbox"/>	

17 How much weight did the mother gain while she was pregnant? _____

18 During pregnancy, check all conditions the mother experienced.

<input type="checkbox"/> None of the below	Describe any checked items
<input type="checkbox"/> Accident	
<input type="checkbox"/> Anemia	
<input type="checkbox"/> Bleeding (severe or frequent spotting)	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> High blood pressure	
<input type="checkbox"/> Illness	
<input type="checkbox"/> Preeclampsia, Eclampsia, or Toxemia	
<input type="checkbox"/> Psychological problems or stress	
<input type="checkbox"/> Surgery	
<input type="checkbox"/> Vomiting (severe or frequent)	
<input type="checkbox"/> Other:	

19 How many pregnancies before this child:	How many were live births:	Miscarriages:	Abortions:
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BIRTH

Birth information is unknown

20 The child was born: Early: _____ weeks On time (38 - 42 weeks) Late: _____ weeks

21 Birth weight: _____ Length: _____

22 Labor lasted:				
23 Labor was:	<input type="checkbox"/> Easy	<input type="checkbox"/> Moderately difficult	<input type="checkbox"/> Very difficult	
24 During delivery:	<input type="checkbox"/> Forceps were used	<input type="checkbox"/> Head was suctioned	<input type="checkbox"/> Other:	
25 Baby was born:	<input type="checkbox"/> Vaginally	Caesarean section:	<input type="checkbox"/> Emergency	<input type="checkbox"/> Planned
If vaginal:	<input type="checkbox"/> Head first	<input type="checkbox"/> Transverse (crosswise)	<input type="checkbox"/> Posterior (rear) first	<input type="checkbox"/> Breech
If C-section explain:				
Labor problems:				

26 Check all that occurred around the time of birth	After birth, the child had the following conditions
<input type="checkbox"/> Fetal distress <input type="checkbox"/> Low placenta blocking fetal exit (Placenta previa) <input type="checkbox"/> Premature placenta separation (Abruptio placenta) <input type="checkbox"/> Placenta compression <input type="checkbox"/> Cord came out before baby (Prolapsed umbilical cord) <input type="checkbox"/> Abnormally slow fetal heart beat (bradycardia) <input type="checkbox"/> Abnormally fast fetal heart beat (tachycardia) <input type="checkbox"/> Other:	<input type="checkbox"/> Appeared inactive <input type="checkbox"/> Bleeding into brain <input type="checkbox"/> Blue baby (oxygen deficiency) <input type="checkbox"/> Breathing difficulty <input type="checkbox"/> Congenital defect <input type="checkbox"/> Heart disease or defect <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Infection <input type="checkbox"/> Large head or <input type="checkbox"/> Small head <input type="checkbox"/> Metabolic disorder <input type="checkbox"/> Physical abnormality <input type="checkbox"/> Seizure <input type="checkbox"/> Skin color abnormality: <input type="checkbox"/> Jaundice <input type="checkbox"/> Other change <input type="checkbox"/> Small or <input type="checkbox"/> Large for gestational (birth) age <input type="checkbox"/> Other:

27 List the baby's Apgar scores: 1st: _____ 2nd: _____ 3rd: _____ Not known

The baby...	Describe
28 <input type="checkbox"/> had medical problems in the days following birth	
29 <input type="checkbox"/> was provided with special equipment	
30 <input type="checkbox"/> was transferred to a special unit or service	

31 How long did the baby stay in the hospital? _____

DEVELOPMENT

32 For each skill, check the description that most closely describes the child's development. Check **Early** or **Late** only if you are sure the child's development was different from most other children. For **Early** and **Late**, write in the age (if known). Then indicate how this child compared to siblings (brothers and sisters).

LARGE MOTOR SKILLS	Early	Average	Late	Compared to siblings child was
Crawled	<input type="checkbox"/>	<input type="checkbox"/> 6-9 mos.	<input type="checkbox"/>	<input type="checkbox"/> Early <input type="checkbox"/> Same <input type="checkbox"/> Late
Walked alone (2-3 steps)	<input type="checkbox"/>	<input type="checkbox"/> 9-18 mos.	<input type="checkbox"/>	<input type="checkbox"/> Early <input type="checkbox"/> Same <input type="checkbox"/> Late

LANGUAGE SKILLS	Early	Average	Late	Compared to siblings child was
Followed simple commands	<input type="checkbox"/>	<input type="checkbox"/> 12-18 mos.	<input type="checkbox"/>	<input type="checkbox"/> Early <input type="checkbox"/> Same <input type="checkbox"/> Late
Used simple sentences	<input type="checkbox"/>	<input type="checkbox"/> 18-30 mos.	<input type="checkbox"/>	<input type="checkbox"/> Early <input type="checkbox"/> Same <input type="checkbox"/> Late


SELF-HELP SKILLS	Early	Average	Late	Compared to siblings child was
Toilet trained	<input type="checkbox"/>	<input type="checkbox"/> 2-3 years	<input type="checkbox"/>	<input type="checkbox"/> Early <input type="checkbox"/> Same <input type="checkbox"/> Late

Can't toilet independently due to physical problem:

OVERALL DEVELOPMENT	Early	Average	Late	Compared to siblings child was
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Early <input type="checkbox"/> Same <input type="checkbox"/> Late

33 Describe any significant developmental problems: There were none

34 Describe the child's muscle control as an infant in each of the four areas:

<p style="text-align: center;">Neck and Head</p> <p><input type="checkbox"/> OK <input type="checkbox"/> Tight <input type="checkbox"/> Weak or loose</p>		<p>Legs</p> <p><input type="checkbox"/> OK <input type="checkbox"/> Tight <input type="checkbox"/> Weak or loose</p>
<p style="text-align: center;">Arms</p> <p><input type="checkbox"/> OK <input type="checkbox"/> Tight <input type="checkbox"/> Weak or loose</p>		<p>Trunk</p> <p><input type="checkbox"/> OK <input type="checkbox"/> Tight <input type="checkbox"/> Weak or loose</p>

35 As a baby, the child: had GE reflux was diagnosed as Failure-To-Thrive was fed through a tube
 The baby's appetite was: good, ate well poor
 The baby's growth was good, grew nicely poor, failed to gain weight as expected

36 Describe the child's early temperament (to age 5). Check one box in each of the 9 areas.

		In-between	
Physical activity level	Low activity level <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> High activity level
Sleeping & eating schedule	Regular & predictable <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Irregular and unpredictable
Unfamiliar situations	Inhibited, cautious <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Uninhibited, spontaneous
Concentration	Concentrated well <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Very distractible
Social	Very shy, timid <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Very friendly
Persistence with activities	Stayed with activities <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Gave up quickly
Sensitivity to environment	Sensitive/easily aroused <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Not sensitive
Intensity	Calm, even tempered <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Overreacted, emotional
Mood	Happy <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Irritable or unhappy

HEALTH

37 Check all of the following that have applied to the child:

<input type="checkbox"/> AIDS, ARC or HIV+	<input type="checkbox"/> Cancer	<input type="checkbox"/> Immune system disorder	<input type="checkbox"/> Metabolic disorder
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Kidney disorder	<input type="checkbox"/> Mumps
<input type="checkbox"/> Anemia	<input type="checkbox"/> Colds (<i>excessive</i>)	<input type="checkbox"/> Learning disability	<input type="checkbox"/> Oxygen deprivation
<input type="checkbox"/> Apnea	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Liver disorder	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Blood disorder	<input type="checkbox"/> Enzyme deficiency	<input type="checkbox"/> Lung disorder	<input type="checkbox"/> Spina bifida
<input type="checkbox"/> BPD	<input type="checkbox"/> Genetic disorder	<input type="checkbox"/> Measles	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Brain disorder	<input type="checkbox"/> Heart disorder/defect	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Whooping cough
Other syndromes, diseases, or conditions: _____			

38 Overall, the child has been sick: Not much at all An average amount Much of the time

39 Currently, the child complains of: Headaches or nausea Stomachaches Vague symptoms

40 What is the child's current: Height: _____ Weight: _____

41 Wears glasses... Farsighted Nearsighted Other: _____
 Uses a hearing aid... Right ear Left ear Other: _____
 Uses other aid: _____

42 The child has had approximately _____ ear infections during the age range from _____ to _____.
Treatments provided: Antibiotics Drainage tubes Other: _____

43 The child has a physical abnormality or unusual physical traits: _____

44 The child has a history of being abused or neglected: _____

The child...	Describe (age, circumstances, problems afterwards)
45 <input type="checkbox"/> has suffered a head injury	
46 <input type="checkbox"/> has lost consciousness or been in a coma	
47 <input type="checkbox"/> had a temperature over 104° F (40° C) for more than a few hours	

48 The child has been in the hospital for a serious accident, injury, or operation. Use an additional sheet if needed.

Age	Reason

49 The child has epilepsy or has had a seizure. No *If checked, indicate the epilepsy type.*

Partial:	<input type="checkbox"/> Simple partial	<input type="checkbox"/> Complex partial (with unconsciousness)	<input type="checkbox"/> Partial evolving into generalized
Generalized:	<input type="checkbox"/> Absence (Petit mal)	<input type="checkbox"/> Myoclonic	<input type="checkbox"/> Clonic <input type="checkbox"/> Tonic <input type="checkbox"/> Tonic-clonic (Grand mal) <input type="checkbox"/> Atonic
Other:	<input type="checkbox"/> Unclassified type	<input type="checkbox"/> Febrile (fever) seizure	<input type="checkbox"/> Had a 30 min seizure <input type="checkbox"/> Seizure from unknown cause
Describe any physical symptoms: _____			
Describe any behavioral symptoms: _____			
Diagnosed with epilepsy at age: _____		How often do seizures occur: _____	
About how many total seizures has the child had: _____		Last seizure occurred: _____	
How many seizure medications is the child on now: _____		How many medications have been tried: _____	

50 List the child's prescription medications (other than for minor or routine illnesses).

Medication	Dose	How often?

51 Child had a very bad reaction or negative side effect to a medication:

If checked, explain: _____

52 Child has swallowed a poison or drug accidentally. If checked, describe (age and circumstance):

53 Check all therapies, services, or medical treatments provided to the child.

<input type="checkbox"/> None of the below	By whom or where	When (ages or dates)
<input type="checkbox"/> Early intervention or Head Start		
<input type="checkbox"/> Occupational therapy		
<input type="checkbox"/> Physical therapy		
<input type="checkbox"/> Psychiatry <input type="checkbox"/> Psychology		
<input type="checkbox"/> Speech/language therapy		
<input type="checkbox"/> Other:		

FAMILY

54 Describe the child's parents.

Name	Mother		Father	
	(include maiden)	age		age
Relationship	<input type="checkbox"/> Biological <input type="checkbox"/> Adoptive <input type="checkbox"/> Stepmother <input type="checkbox"/> Foster		<input type="checkbox"/> Biological <input type="checkbox"/> Adoptive <input type="checkbox"/> Stepfather <input type="checkbox"/> Foster	
Education (years or degree)				
Occupation (current or prior)				
Major health problems	<input type="checkbox"/> Deceased		<input type="checkbox"/> Deceased	
Hobbies				
Lives with this child?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

55 **Children:** Write in the age and sex of the children beginning with the oldest child. For example, a male 5 yrs. old = 5M. If deceased add "D" after age at death.

Children (write in age and sex):	Age & Sex of Children							
	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Other people living in the house:								

56 The child has been raised by:

	Age placed	Circumstances of placement
<input type="checkbox"/> Biological mother <input type="checkbox"/> Adoptive parents...		
<input type="checkbox"/> Biological father <input type="checkbox"/> Foster parents...		
<input type="checkbox"/> Biological relatives <input type="checkbox"/> Institutional care...		
<input type="checkbox"/> Other:		

57 Parents' present marital status:		Age of child when separated or divorced
<input type="checkbox"/> Married, living together	<input type="checkbox"/> Separated...	
<input type="checkbox"/> Unmarried, living together	<input type="checkbox"/> Divorced...	
<input type="checkbox"/> Never married, living apart	<input type="checkbox"/> Other:	

58 Check all that exist in the child's **biological** family (parents, brothers, sisters, grandparents, aunts, uncles). For grandparents, aunts and uncles check the side of the family.

<input type="checkbox"/> This information is unknown	Relative(s)	Side of Family		Describe
		Mother	Father	
<input type="checkbox"/> Attention deficit/hyperactivity		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Brain or neurologic disease		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Developmental delay		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Epilepsy or seizure		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Genetic disorder		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Learning disability		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental retardation		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Psychiatric disorder		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Speech or language disorder		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other		<input type="checkbox"/>	<input type="checkbox"/>	

59 Which of the child's biological relatives write or perform many activities with their left-hand? No one

Mother Father Brother or sister Grandmother(s) Grandfather(s)

60 Languages spoken in the home: a) _____ b) _____

61 How is the child disciplined? a) _____ b) _____

62 Check all of the child's usual recreational activities and hobbies.

<input type="checkbox"/> Reading	<input type="checkbox"/> Watching TV	<input type="checkbox"/> Sports	<input type="checkbox"/> Video games	<input type="checkbox"/> Collecting things	<input type="checkbox"/> Computer
<input type="checkbox"/> Art	Music: <input type="checkbox"/> listening	<input type="checkbox"/> playing	<input type="checkbox"/> Writing	Playing: <input type="checkbox"/> alone	<input type="checkbox"/> with others
<input type="checkbox"/> Other:					

63 Major family stresses or changes in the past year have been: None

<input type="checkbox"/> Marital problem or conflict	<input type="checkbox"/> Divorce	<input type="checkbox"/> Family relocation
<input type="checkbox"/> Change of school for this child	<input type="checkbox"/> Legal problem	<input type="checkbox"/> Parent job problem or job change
<input type="checkbox"/> Significant illness or accident of family member:		
<input type="checkbox"/> Other:		
How much stress have these changes caused the child: <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		

SCHOOL

64 Present school: Name

Street _____

City _____ State _____ Zip _____

Telephone: _____ Principal _____

	Explain
65 <input type="checkbox"/> Child repeated a grade	
66 <input type="checkbox"/> Child skipped a grade	
67 Child has been in the following classes: <input type="checkbox"/> Resource room <input type="checkbox"/> Emotional/behavior problems <input type="checkbox"/> LD class (full time) <input type="checkbox"/> Advanced instruction <input type="checkbox"/> LD class (part time) <input type="checkbox"/> Other: _____	
68 <input type="checkbox"/> The child is in a special class or program now	

69 Child likes school: All or most of the time Sometimes Almost never

70 In school, the child:

Gets along well with the other children and has friends OR Does not get along with the other children

Gets along well with the teacher OR Does not get along with the teacher

71 Describe any teacher concerns about the child's schoolwork or behavior: _____

72 The child's current grades are (choose the appropriate system): Ungraded class

A & B B & C C & D D & F

Outstanding Good Satisfactory Improvement needed Unsatisfactory

90's 80's 70's 60's Below 60

Compared to previous years these grades have: stayed the same improved declined

The child's best subject(s): _____

The child's hardest subject(s): _____

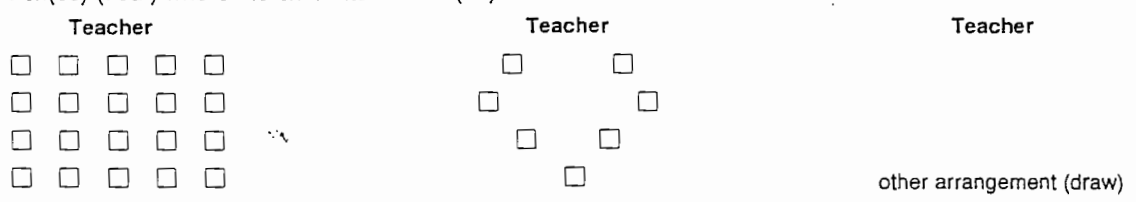
73 School activities the child is involved in: _____

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

Less than 2 weeks 2 weeks to 4 weeks 5 weeks to 8 weeks More than 8 weeks

Explain: _____

75 Fill-in the box(es) (seat) where the child sits in class(es) in relation to the teacher. Note the classes if more than one.



Hours spent in school per day: _____	Class size(s): _____	<input type="checkbox"/> Seating changes often
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PREVIOUS EVALUATIONS

76 Check the tests or evaluations that have been done in relation to the problem.

<input type="checkbox"/> No tests have been done	Date	Test done more than once	Results
<input type="checkbox"/> Blood work	/ /	<input type="checkbox"/>	
<input type="checkbox"/> CT scan	/ /	<input type="checkbox"/>	
<input type="checkbox"/> EEG	/ /	<input type="checkbox"/>	
<input type="checkbox"/> Genetic testing	/ /	<input type="checkbox"/>	
<input type="checkbox"/> Hearing testing	/ /	<input type="checkbox"/>	
<input type="checkbox"/> MRI or PET	/ /	<input type="checkbox"/>	
<input type="checkbox"/> Neurologist's exam	/ /	<input type="checkbox"/>	
<input type="checkbox"/> Occupational therapy evaluation	/ /	<input type="checkbox"/>	
<input type="checkbox"/> Physical therapy evaluation	/ /	<input type="checkbox"/>	
<input type="checkbox"/> Psychiatric evaluation	/ /	<input type="checkbox"/>	
<input type="checkbox"/> Psychological or neuropsychological testing	/ /	<input type="checkbox"/>	
<input type="checkbox"/> School testing	/ /	<input type="checkbox"/>	
<input type="checkbox"/> Speech/language testing	/ /	<input type="checkbox"/>	
<input type="checkbox"/> Vision testing	/ /	<input type="checkbox"/>	
<input type="checkbox"/> Other	/ /	<input type="checkbox"/>	

77 When was the child's last check-up from a pediatrician? _____

Findings: _____

78 What is the name of the physician, psychologist, social worker, school authority, or other professional we may contact who is familiar with the child's problems?

Name # 1	Name # 2
Street	Street
City, ST, Zip	City, ST, Zip
Telephone	Telephone
Profession	Profession

COMMENTS

79 Please add any helpful comments, information or concerns that have not been covered above.

Thank you for taking the time to carefully complete this questionnaire.

Child Neuropsychological History by Glen D. Greenberg, Ph.D.