The Center
for Neuropsychology
& Counseling P.C.

Questionnaire for Patients 18 Years Old or Younger

The following questions are asked to help us better understand your child. This information is very important in making an accurate diagnosis and providing recommendations. Please read the questions carefully and answer as fully as possible. We will have the opportunity to discuss these questions in detail at the time of your appointment. Thank you.

PLEASE PRINT

CHILD'S NAME _____ TODAY'S DATE _____

GENDER _____ BIRTHDATE _____ AGE _____

SCHOOL _____ GRADE _____

CHILD'S HOME ADDRESS _____

_____

_____

HOME PHONE_____ OTHER PHONE_____

EMAIL ADDRESS _____

PERSON COMPLETING FORM _____

RELATIONSHIP TO PATIENT _____

REFERRED BY: _____

PHONE: _____ FAX:_____

What are your concerns about this child? What do you feel his/her difficulties/problems are at this time?

_____

_____

_____

_____

What strategies have you tried to help? _____

_____

_____

11/2/16 1:51 PM

What questions do you have that you hope this consultation will answer? _____

_____

_____

Has your child ever been evaluated by a health care or educational professional?
YES_____ NO_____ If yes, please explain: (**Please provide a copy of all records**): _____

_____

_____

Has a psychologist or other professional ever diagnosed this child? YES_____ NO_____ If yes, please explain:

_____

_____

_____

What treatment, if any has your child received for the above problems? _____

_____

_____

PLEASE LIST ANY PROFESSIONALS WHO HAVE SEEN THE CHILD/FAMILY:

Name	Date(s) seen	Procedure (testing, therapy, MRI)

ARE YOU THE CHILD'S BIOLOGICAL PARENT? YES NO

IF NO, ARE YOU THEIR LEGAL GUARDIAN? YES NO

PARENTS' MARITAL STATUS_____ IF MARRIED, HOW LONG?_____

If divorced, when was the divorce final? _____

Is there a written custody agreement? _____

If so, who has primary physical custody and what are the arrangements? _____

_____

_____

Does this child have any step-parents?

_____

_____

_____

PLEASE LIST EVERYONE IN THE FAMILY AND OTHERS LIVING IN THE HOME:

NAME AGE BIRTHDATE RELATIONSHIP TO CHILD

_____

_____

_____

_____

_____

Mother:

Name: _____

Address (if different from child): _____

Phone (if different from child):HOME _____WORK _____

Date of Birth: _____ Age: _____ Highest Grade Completed _____

Occupation/Profession: _____

Current place of employment: _____

Were you ever in any type of special education class? YES___ NO___ If yes, please explain: _____

_____

For the child's mother, please indicate if you or any member of ***your birth family*** has had any of the following:

Condition	**You**	**Your Mother**	**Your Father**	**Your Siblings**	**Other (please specify)**
Attention problems					
Math difficulties					
Discipline problems					
Failing subjects					
Failing grades					
Reading difficulties					
Writing difficulties					
Social situations					

Father:
Name: _____

Address (if different from child):_____

Telephone (if different from child): HOME _____WORK _____

Birthdate: _____ Age: _____ Highest grade completed _____

Occupation/Profession: _____

Current place of employment: _____

Were you ever in any type of special education class? YES___ NO___ If yes, please explain: _____

_____

For the child's father please indicate if you or any member of ***your birth family*** has had any of the following:

Condition	**You**	**Your Mother**	**Your Father**	**Your Siblings**	**Other (please specify)**
Attention problems					
Math difficulties					
Reading difficulties					
Writing difficulties					
Discipline problems					
Failing subjects					
Failing grades					
Social problems					

PRENATAL HISTORY

Pregnancy Complications: (Please place an "X" for those that apply to your pregnancy with this child):

X	Condition	X	Condition	X	Condition
	Anemia		High blood pressure		Serious injury
	Confined to bed		High fever		Special diet
	Diabetes		Hospitalizations		Surgery
	Drug/alcohol use/abuse		Incompatible Rh factor		Toxemia
	Depression or Anxiety		Infections		Unusual worries/stress
	Excess weight gain		Morning sickness		Weight loss
	Excessive bleeding		Rubella		Other _____
	Excessive vomiting		Seizure		

PERINATAL HISTORY

DELIVERY:

Check all that apply to describe the birth of this child:

_____spontaneous delivery
_____induced delivery
_____late delivery (_____weeks)
_____premature delivery (_____ weeks)
_____Cesarean section (C-section)
_____normal presentation
_____breech presentation (feet 1st)
_____multiple births (e.g. twins)
_____duration of labor (_____hours)
_____local anesthesia (epidural/spinal)
_____general anesthesia
_____use of Pitocin
_____pain medication
_____muscle relaxant
_____forceps used
_____vacuum used
_____fetal distress
_____hemorrhage

Birth Weight: _____ Length: _____

APGAR Scores: One min._____ Five min._____

Place an "X" for any of those that described your child shortly after birth:

___jaundiced
___ use of incubator
___ rashes
___ problems eating/digestion
___ Other _____
___ very quiet
___ very active
___ breathing problems
___ baby given oxygen
___ blood transfusions
___ problems sucking
___ use of heart monitor
___ Failure to Thrive

Were there any problems with labor and delivery? YES___ NO____ If yes, please explain: _

_____

_____

Please report any other problems or comments regarding this child when he/she was a newborn: _____

_____

INFANCY AND EARLY CHILDHOOD: (Place an "X" for those items that described your child)

___ Colic
___ Sleeping problems
___ Active
___ Uncoordinated
___ Unclear speech
___ Other specify: _____

___ Head-banging
___ Irritability
___ Did not enjoy cuddling
___ Digestive problems
___ Difficulty separating

___ Feeding problems
___ Restless
___ Accident-prone
___ Chronic infections
___ Digestive problems

DEVELOPMENTAL MILESTONES: (Please provide the **approximate age** for each milestone)

Crawled:_____
First steps:_____
Ran: _____
Rode two-wheeler _____

First syllables ("ma ma"): _____
First words: _____
2-3 Word Phrases: _____
Complete Sentences: _____

Age Toilet Trained (Day):_____

Toilet Trained (Night): _____

Does your child have wetting or soiling accidents? YES_____NO _____

Is your child right-handed, left-handed or mixed? _____

Has your child ever:

_____Had a stutter
_____Grind his/her teeth
_____Had tic/nervous twitches

_____Had a speech evaluation?
_____Rocked back and forth
_____Stare off/go blank

Would you describe your child as coordinated/athletic? YES_____ NO_____ Please explain: _____

_____

Please describe any other problems or comments regarding your child's infancy and early childhood development: _____

_____

_____

MEDICAL HISTORY

Has your child undergone any type of surgery? YES_____ NO_____ If yes, please explain:

_____

_____

Has your child suffered any type of head injury? YES___ NO___ If yes, please indicate your child's age, how he/she was injured and whether or not consciousness was lost at the time of the incident: _____

_____

Has your child ever experienced convulsions or seizures? YES_____ NO_____ If yes, please indicate the nature of the convulsions and whether or not these occurred with high fevers; please indicate the child's age at the time of the convulsions: _____

_____

_____

Has your child experienced persistent high fevers? YES____ NO____ If yes, please explain: _____

_____

_____

Was your child ever in a car when it was in an accident (even a minor one)? YES_____ NO_____ If yes, please explain: _____

_____

_____

Does your child suffer from allergies? YES_____ NO_____ If yes, please explain type of allergic reaction and the treatment he/she is receiving, if any: _____

_____

_____

Has your child suffered from persistent ear infections? YES__ NO__ If yes, please explain: _____

_____

_____

Has your child been hospitalized for any illness not covered thus far? YES_____ NO____
If yes, please explain: _____

_____

_____

Please list any medication your child is currently taking:

Medication	Dose (e.g. 20mg four times a day)	Date Started

FAMILY HISTORY

Place an "X" next to any medical condition your child or any member of your family has had/has.

X	Condition	X	Condition
	Asthma		Hydrocephalus
	Asperger's Syndrome		Lead poisoning
	Attention Deficit Hyperactivity Disorder		Learning Disability
	Autism/Pervasive Developmental Disorder		Meningitis
	Bipolar Disorder		Mental retardation
	Cerebral palsy		Migraines
	Cystic Fibrosis		Multiple sclerosis
	Diabetes		Neurological Problems
	Drug or Alcohol Use/Abuse		Seizures
	Emotional problems (depression/anxiety)		Schizophrenia/psychosis
	Epilepsy		Speech/Language Problems
	Fragile X Syndrome		Tourette's Syndrome/Tics
	Hearing difficulties		Vision difficulties

PRESENT MEDICAL STATUS

Current Health: _____ (Please rate poor, fair, good, excellent, etc.)

Is your child in any way physically ill at this time? YES__ NO__ If yes, please explain and specify if your child is currently being treated for this illness: _____

_____

Does your child wear glasses or contacts? _____
Date of last eye exam: _____

Does your child have any difficulty hearing? _____
Date of last hearing exam: _____

How would you describe your child's sleep? _____
How many hours of sleep per night does your child typically get? _____

How would you describe your child's appetite? _____

Please check all that apply to your child:

_____ Mid-night awakenings
_____ Difficulty falling asleep
_____ Difficulty waking up
_____ Snores
_____ Nightmares/night terrors
_____ Recent weight gain or loss
_____ Low variety of foods in diet
_____ Poor/distorted body image

Is your child currently or previously involved in any type of professional mental health treatment (i.e., therapy, family counseling, etc.)? YES _____ NO_____ If yes, please list:

Clinic	Date(s) seen	Contact Person	Phone Number

SOCIAL HISTORY

Describe your child socially (friends, fights, dating, popularity, participation, etc.): _____

_____
_____
_____
_____

Does your child or has your child ever:

Had problems relating to playmates, classmates or peers? _____

Fight frequently with peers? _____

Prefers playing with younger children? _____

Had difficulty making friends? _____

Prefer to play alone? _____

Are there children in the neighborhood with whom the child could play? _____

What role does the child usually take in social settings (leader, follower, etc.)? _____

What activities does your child enjoy/participate in? (sports, hobbies, etc.) _____

_____

_____

_____

Do you suspect your child to be using or abusing drugs or alcohol? If yes, please explain. __

_____

_____

Has your child had any legal problems? (contact with juvenile justice, arrests, citations, etc.)

_____

_____

Is your child sexually active? YES_____NO _____

Does your child smoke? YES _____NO _____

Describe the best things about your child: _____

_____

_____

_____

_____

EDUCATIONAL HISTORY:

Name of Current School: _____

Home School District: _____

School Address: _____

_____

Grade Placement: _____

Classroom Type (i.e., regular, LD, resource room, etc.): _____
Number of students in class: _____

Teacher's Name: _____
Principal's Name: _____
School Psychologist or Counselor: _____

Has your child ever had an Individual Education Plan (IEP) or Chapter 504 Agreement? YES___ NO___

Under what educational classification? (Autism, Specific Learning Disability, Emotional Disturbance, Mentally Gifted, Hearing Impaired, Speech/Language Impaired, Traumatic Brain Injury, Visually Impaired, Mentally Deficient, Multiple Handicapped) _____

_____

_____

Please list the name(s), addresses and telephone numbers of any other persons involved in your child's education who you feel we should contact:

_____

_____

_____

_____

Did your child attend a preschool program? YES_____ NO_____

Did your child repeat any grades? YES_____ NO_____ If yes, which ones and for what reason(s)? _____

_____

Did your child ever skip a grade? If so, which one? _____

Does your child have a history of failing subjects? YES___ NO___ If yes, which ones? ____

_____

_____

What are your child's most recent grades?

_____ Reading/English _____ Math (specify which math_____) _____ Science
_____ Language Arts _____ Social Studies _____ Gym
_____ Art _____ Music
_____ Other (specify _____)

Does your child currently receive special education services? YES _____ NO _____

If yes, specify type and frequency. _____

_____

_____

Does your child have any difficulty with Reading? _____

_____

Does your child have any difficulty with Math? _____

_____

Does your child have any difficulty with Writing? _____

_____

Please list any unusual and/or traumatic event(s) in your child's life which you feel may have impacted upon his or her development (i.e., abuse, birth of a sibling, death in the family, divorce, illnesses, frequent school changes, familial moves, financial problems, anything.) or any other information you feel may be helpful:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____