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Children's Neuropsychological Services, PLLC

834 Kenwood Ave., Suite 3
Slingerlands, NY 12159
Phone: 518-439-1641
Fax: 518-439-1625

Pediatric History Form

Please answer all questions as well as you can.

Personal Information:

Child's Name _____

Date of Birth & Current Age _____/_____/_____ Age: _____ Grade_____

Today's Date _____/_____/_____

Person Completing This Form: _____

Relationship to Child _____

Do you have legal custody? Yes No

Referral Information:

Who referred you for this evaluation?

Child's primary care physician:

Phone: _____

Address: _____

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What are your main concerns about this child? What is the reason for this evaluation?

At what age was this child's problem first noted? By whom?

Medical History:

List the names and doses of ***all*** the medications this child is taking **at this time**. Also, provide the reason the medication was prescribed.

Age of mother at time of delivery: _____

Any complications experienced by mother or baby ***during pregnancy***?

Did the mother drink alcohol during pregnancy? If yes, approximately how many drinks per week?

Did the mother smoke cigarettes during pregnancy? If yes, approximately how many per day?

Did the mother use street drugs during pregnancy? If yes, what drugs, how much, how often?

What medications did the mother take during pregnancy?

Length of pregnancy: _____ weeks

Describe any complications **during delivery** (e.g., fetal distress, insufficient oxygen, meconium aspiration, jaundice):

Baby was delivered: Vaginally By C-section

If by C-section, what was the reason?

Baby weighed: _____ lbs. _____ oz.

Did the baby have any respiratory difficulties or other complications immediately or soon after birth? If yes, please explain:

Did the baby require treatment in the Neonatal Intensive Care Unit (NICU)? If so, how long?

How soon after birth was the baby discharged from the hospital?

Any medical problems in first year of life? If yes, please describe.

Does/did this child have any medical conditions (check all that apply)?

___Febrile seizures	___Loss of consciousness
___Head injury	___Lead poisoning
___Epilepsy	___Heart condition
___Diabetes	___Meningitis
___Asthma	___Allergies

___Other _____

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Has this child been evaluated by a neurologist?
If yes, neurologist's name_____

City_____ Date of exam_____

Reason for exam_____

Findings_____

Motor Development:
Did this child experience any delays in early gross motor development (such as rolling over, crawling, walking)?

Has this child ever received physical therapy? If yes, from age ____ to age _____.

Describe any current motor problems:

What is your child's hand preference? ____Left ____Right

Does this child display any repetitive or unusual motor behaviors? (check all that apply):

___hand flapping	___rocking
___eye rolling	___head flicking
___facial grimacing	___eye rubbing
___hand rubbing	___clicking/clucking sounds
___throat clearing	___pacing
___picking	___Other:_____

Describe any problems with *fine motor* abilities (such as doing buttons or zippers, tying shoes, handwriting):

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Does this child have exceedingly strong negative reactions to certain sensory experiences?

Check all that apply:

___food textures	___feel of clothing	___other textures (e.g. playdough)
___human touches/hugs	___noise	___light
___tastes	___voices	___other_____

Has this child ever received occupational therapy? If yes, from age ____ to age _____.

Language Development:

Did this child have any delays in early speech/language development (such as babbling, imitating sounds/words, speaking first words or putting words together to make sentences)?

Has this child ever received speech and language therapy? If yes, from age ____ to age _____.

Describe any current language problems:

Have this child's language abilities deteriorated? If yes, please describe.

Were there problems with multiple ear infections?

Did this child have PE tubes placed?

Are there problems with hearing? If yes, please describe:

Are there problems with vision? If yes, please describe:

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Temperament and Social Development:
Did this child's early social and play skill development seem typical (for example, looking at caregivers, responding positively to caregiver interactions, enjoying early games like Peek-a-Boo)?

As this child got older, did he/she engage in imitative play and fantasy/imaginative play (such as playing house, superheroes, cops and robbers, etc.) *with* his/her peers? If no, please describe.

Now this child gets along best with children:

___Same age ___Younger ___Older or ___Adults

Does this child have difficulty making or keeping friends or have trouble getting along with other children his/her age? If yes, please describe.

Does this child seem to understand social cues well (e.g., when others are angry or upset). If no, please describe.

Describe any other current social problems:

What time does this child go to sleep? Wake up?

Does this child snore?

Are there problems with sleep? If yes, please describe:

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Attention and Activity Level:
Has this child been evaluated for attention deficit hyperactivity disorder?

If yes, doctor's name_____

Date of exam_____

Was a diagnosis made? If yes, what diagnosis?_____

This child has problems with the following: (check all that apply)

___short attention span	___easily distracted	___easily sidetracked
___forgetful	___disorganized	___following directions
___loses things	___multitasking	___finishing tasks

This child has problems with the following: (check all that apply)

___sitting still	___playing calmly/quietly	___fidgety
___excessive energy	___difficulty sleeping	___movement/talking in sleep
___lacks self control	___acts without thinking/impulsive	

Interests and Play/Leisure Activities:
In what activities does this child engage in his/her free time?

Does this child have interests that are unusual for his/her age/peer group? If yes, please describe.

Does this child have excessive interest/preoccupation with a particular topic or activity? If yes, please describe.

Does this child engage in any repetitive or ritualized activities? (e.g., lining up toys, replaying same play scheme over and over)? If yes, please describe.

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Behavior:
Describe the positive aspects of this child's personality/behavior:

Does this child have difficulty following rules? Or, is he/she argumentative? If yes to either, please explain.

Is this child verbally or physically aggressive? If yes, please describe:

Does this child get "in trouble" in school? If yes, please describe.

Are this child's problems the same at home and at school? If not, please describe.

What type of discipline has been effective with this child?

Do you feel that you and your spouse/partner/other caregivers are "on the same page" regarding discipline and child rearing? If no, please explain.

Have you or your immediate family members received any parenting training/therapy?

If yes, therapist's name_____

City_____ Dates of intervention_____

Reason for intervention_____

Outcome_____

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Psychological:

Has this child had a psychiatric/psychological exam? If yes, when?
If yes, doctor's name_____

Reason for exam_____

Has this child been in any kind of therapy/counseling?
If yes, therapist's name_____

City_____ Dates of treatment_____

Reason for treatment_____

Does this child worry a lot? If yes, please describe.

Does this child engage in any routines/rituals designed to reduce anxiety (e.g., handwashing, following rigid sequences, counting, rigid dinner/bedtime routines)? If yes, please describe.

Regarding mood, this child is *usually*:

___Happy/cheerful	___Sad /depressed	___Irritable
___Moody	___ Mellow/calm	___Excitable

Has this child ever expressed suicidal thoughts? If yes, please describe.

Does this child have a history of being sexually or physically abused?

Is there concern about alcohol or drug use?

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Academics:

Name of Child's School _____ District _____

Placement: ___Regular Classes ___Integrated ___Self Contained ____Home schooled

Any grades repeated or skipped? If yes, please describe.

Describe this child's academic strengths:

This child's teachers report problems in: (Check all that apply)

___Reading	___Attention
___Spelling	___Concentration
___Arithmetic	___Behavior
___Writing	___Social Adjustment
___Other_____	

Please list the names of each school that this child has attended.

_____grade(s)_____

_____grade(s)_____

_____grade(s)_____

_____grade(s)_____

_____grade(s)_____

_____grade(s)_____

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My child's intelligence is likely:

___Below Average ___Average ___High Average ___Superior

At what grade level do you believe this child is functioning in the following areas?

Reading _____ Writing_____ Math _____

Does this child have an IEP or 504 Plan?

Does he or she receive Academic Intervention Service (AIS)?
What special services, accommodations and modifications does he/she currently receive? Check all that apply:

___Resource room	___Reading Intervention	___Math Intervention
___Occupational Therapy	___Physical Therapy	___Speech & Lang. Therapy
___Aide	___Reader	___Scribe
___Testing Modifications	___Social Skills	___Counseling
___Study skills	___Adaptive PE	___other _____

Family History:

Please provide the following about primary caregivers, such as mother, father, guardian. (This section continues on the next page):

Name: _____ Relationship to child: _____

Address:_____

Home phone: _____ Work Phone: _____

Age: _____ Highest grade (degree) completed in school:_____

Occupation: _____ ___Fulltime ___Part-time

Is this person biologically related? If no, please explain: _____

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Name: _____ Relationship to child: _____

Address:_____

Home phone: _____ Work Phone: _____

Age: _____ Highest grade (degree) completed in school:_____

Occupation: _____ ___Fulltime ___Part-time

Is this person biologically related? If no, please explain: _____

This child is: ___Natural ___Adopted (date:_____) ___Foster (dates:_____)

This child's parent are: ___Married ___Divorced (date:_____)
___Separated (date:_____) ___Never Married

Please list all brothers and sisters, including full, half and step-siblings.

		Sex	Living with Child?				
Name: _____	Age: _____	____	☐ Yes	☐ No	Full	Half	Step
Name: _____	Age: _____	____	☐ Yes	☐ No	Full	Half	Step
Name: _____	Age: _____	____	☐ Yes	☐ No	Full	Half	Step
Name: _____	Age: _____	____	☐ Yes	☐ No	Full	Half	Step
Name: _____	Age: _____	____	☐ Yes	☐ No	Full	Half	Step

Please list anyone else living in this child's home, and indicate their relationship to this child.

Are there any significant stressors or pressures on the family?

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Do/did any family members (parents, siblings, grandparents, cousins, aunts, uncles) have learning or developmental problems (e.g., learning disability, speech/language problems, mental retardation, autism, Asperger's)? If yes, please explain:

Do/did any family members (parents, siblings, grandparents, cousins, aunts, uncles) have neurologic disorders (e.g., epilepsy, multiple sclerosis)? If yes, please explain:

Do/did any family members (parents, siblings, grandparents, cousins, aunts, uncles) have psychiatric disorders (e.g., depression, anxiety, bipolar disorder, schizophrenia)? If yes, please explain:

Do/did any family members (parents, siblings, grandparents, cousins, aunts, uncles) have problems similar to this child? If yes, please explain:

Other Information:

Is this evaluation going to be used in court, an impartial hearing or other legal proceeding? If yes, please describe.

Please use the rest of this page or a separate sheet of paper to add any additional information that you believe will be helpful:

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