NEUROPSYCHOLOGY ASSOCIATES, P.C.

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CHILDREN'S HISTORY FORM

INSTRUCTIONS TO PARENTS: Please complete this form and return it to us before your child's appointment. Fill out the form to the best of your knowledge. If some questions are not applicable to your child, write NA. If you need more space or wish to make any additional comments, please attach a separate sheet.

Name of person filling out this form: _____
Relationship to child: _____
Date: _____

Child's Name: _____ Birth date: _____
Referred by: _____ Phone: _____

Reason for Consultation (What are the main questions you would like answered?)
_____
_____
_____

Pediatrician:_____ Phone: _____
If you would like a copy of the report to go to your child's pediatrician, please list the doctor's address here. _____
_____
_____
_____

Current School:_____ Grade:_____

FAMILY HISTORY
(List parents first, then children in birth order)

	NAME	check if living in the home	AGE	OCCUPATION	EDUCATION/ GRADE
father					
step-father					
mother					
step-mother					
child					
child					
child					
child					

Are there significant marital conflicts? Yes _____ No _____
Are there significant conflicts between child and parent? Yes _____ No ____
Are there significant conflicts between your children? Yes _____ No _____
Do parents agree on how to discipline your child? Yes _____ No _____
Who disciplines and how? _____
_____
How does your child respond to discipline? _____

PREGNANCY:
Is this child adopted? No _____ Yes _____
Did you have any of the following complications during this pregnancy? If so, indicate which month.

Anemia _____ High Blood Pressure _____
Swollen Ankles _____ Kidney Disease _____
Heart Disease _____ German Measles _____
Toxemia _____ Staining _____
Bleeding _____ Vomiting _____
Virus _____ Threatened miscarriage/early contractions _____
Rh or other blood incompatibility_____

List any other complications you may have had: _____
_____
List any chronic illness (s) such as diabetes, kidney infection, thyroid problem, etc. you were suffering from during pregnancy: _____
List any other illnesses suffered during this pregnancy: _____
_____
List any hospitalizations during this pregnancy (date and reason): _____
_____
List any surgeries during this pregnancy: _____
_____
List any Injuries suffered during this pregnancy: _____
List any medications taken during this pregnancy: _____
_____

BIRTH HISTORY OF THIS CHILD:

Name of hospital:_____
Hours from first contraction to birth: _____
List any medication (s) administered and why: _____
_____
Name any anesthesia administered during childbirth: _____
Was labor induced? Yes ____ No ____
If yes, how and why? _____
Was your baby born head first? Yes _____ No _____ Don't Know _____
Were forceps used? Yes _____ No _____ Don't know _____
If yes, why?: _____
Did you have a cesarean section? Yes _____ No _____ If yes, why? _____
Did your baby have any bruises? Yes _____ No _____ If yes, where? _____
Did your baby have any birthmarks: Yes _____ No ____ If yes, where? _____
Was this a multiple birth? Yes _____ No _____ If yes, how many? _____
Did your baby have breathing problems? Yes _____ No _____ Don' know _____
Was the cord around the neck? Yes _____ No _____ Don't know _____
Did your baby cry quickly? Yes _____ No _____ Don't know _____
Was your baby's color normal? Yes ___ No ___ Don't know ___ Blue? ___ Yellow? _____
If your baby's color was yellow (jaundiced), did he/she receive any of the following?
Oxygen Yes ___ No ___ How long _____
Transfusions Yes ___ No ___ How many_____
Phototherapy Yes ___ No ___ How long _____
Were there any other complications before you took your baby home? Yes ___ No ___
If yes, what _____
Was your baby placed in an incubator or special crib? Yes ___ No ___ How long _____
How long after birth did you take your baby home? _____

EARLY HISTORY:

General:

Did your baby have feeding problems? Yes ___ No ___ If yes, describe them _____
_____
Was your baby colicky? Yes ___ No ___ How long _____
Did your baby require formula changes? Yes ___ No ___ If yes, describe them _____
_____
Did your baby have difficulty as an infant with the following?
Sucking ___ Chewing ___ Drooling past 2 ½ months ___
Was your baby normally active? Yes ___ No ___
Was your baby limp? Yes ___ No ___
Was your baby stiff? Yes ___ No ___
Did your baby show unusual trembling? Yes ___ No ___ If so, when_____
As an infant or a toddler did your child have poor muscle control (i.e., weakness)? Yes ___ No ___
If yes, which of the following: Neck ___, Trunk ___, Legs ___ Chest ___, Arms ___, Fingers ___
Did your baby fail to grow normally? Yes ___ No ___
Did your baby fail to gain weight? Yes ___ No __
Was this baby different in any way from his/her siblings? Yes ___ No ___
Describe how_____

Toileting:

Indicate your child's development by circling one description.

Toilet trained Early Average (13-36 mos.) Late

Did your child have enuresis (bedwetting)? Yes _____ No _____

If so, at what age did it start? _____ Age it was controlled: _____.

Did your child have urine accidents during the day? Yes _____ No _____

Did your child have soiling? Yes _____ No _____

Motor Milestones:

At what age did your child:

Sit alone _____ Pedal tricycle _____ Swim.._____

Tie shoes _____ Ride bicycle _____

Walk without holding on _____ Dress self _____

Feed self _____

Which hand does your child prefer? Right _____ Left _____ Age established _____

Does your child switch hands? Yes _____ No ____

Indicate your child's development by circling one description.

Crawled early Early Average (6-9 mos.) Late

Walked alone (2-3 steps) Early Average (9-18 mos.) Late

Language Milestones:

At what age did your child:

Speak first words _____ Put 2-3 words together _____ Sentence structure _____

Speech problems? Yes ___ No ___ If yes, describe _____

Indicate your child's development by circling one description.

Followed simple commands Early Average (12-18 mos.) Late

Used singles words/sentences Early Average (12-24 mos.) Late

MEDICAL HISTORY

What is your child's height? _____ft. _____in. Weight? _____ lb.

Has your child ever had high or prolonged fevers? Yes _____ No _____

Did your child have frequent ear infections? Yes _____ No ____

If yes, were tubes placed? Yes _____ No ____

Does your child have any visual defects? Yes ____ No _____

Does your child have any hearing defects? Yes _____ No _____

Has your child broken any bones? Yes _____ No _____

Does your child frequently complain of any of the following:

Headache _____ Stomachaches _____ Trouble with vision _____

Dizziness _____ Chronic constipation _____

Weakness _____ Chronic diarrhea _____

Nausea _____ Trouble with hearing _____

Has your child ever had a temperature of 104° (40° C) or higher for more than a few hours?

Yes ___ No ___ If yes, what age or ages? _____

How long did it last? _____

Did your child ever have a seizure due to a fever or unknown cause? Yes ___ No ____

If yes, describe (age, nature of the seizure). _____

_____

Did your child ever eat paint, paper, etc.? Yes _____ No ____

Has your child ever accidentally swallowed any poison, drug, or non-food object? Yes ___ No ___

If yes, what age (s)? _____ Describe _____

_____

Has your child ever participated in team sports or other competitive sports? Yes ____ No ____
If yes, which ones? _____
Has your child ever been dazed ("dinged," "bell rung") or knocked unconscious while involved in sports? Yes ____ No ____
If yes, please describe _____
Has your child ever suffered a brain injury in an accident or assault? Yes ____ No ____
If yes, please describe _____

What time does your child typically go to bed? _____
What time does your child typically arise? _____
Does your child have any trouble falling asleep? Yes ____ No ____
Does your child have any trouble staying asleep throughout the night? Yes ____ No ____
Does your child sleepwalk? Yes ____ No ____
Does your child snore? Yes ____ No ____
Does your child have trouble with excessive movement when sleeping, such as "restless legs"?
Yes ____ No ____
Does your child have trouble with nightmares? Yes ____ No ____

Please check the following diseases and/or conditions that your child has had:

_____ Anemia	_____ Encephalitis	_____ Metabolic disorder
_____ Asthma	_____ Enzyme deficiency	_____ Mumps
_____ Bleeding disorder	_____ Genetic disorder	_____ Oxygen deprivation
_____ Blood disorder	_____ Heart disorder	_____ Pneumonia
_____ Brain stroke	_____ Jaundice	_____ Rheumatic fever
_____ Broken bones	_____ Kidney disorder	_____ Scarlet fever
_____ Cancer	_____ Leukemia	_____ Tuberculosis
_____ Chicken pox	_____ Lung disorder	_____ Whooping cough
_____ Colds (excessive)	_____ Measles	_____ Other problems

What therapies have been provided to your child?

____ No therapies	____ Speech therapy
____ Occupational therapy	____ Chiropractic treatment
____ Physical therapy	____ Vision therapy
____ Psychological therapy (counseling)	____ Biofeedback
____ Cognitive rehabilitation services	____ Homeopathic treatments

Did anyone in your immediate family or other relative have any of the following? If so, who?

Problems similar to your child	Yes _____	No _____	Who _____
Neurological disease	Yes _____	No _____	Who _____
Seizures (epilepsy)	Yes _____	No _____	Who _____
Emotional problems	Yes _____	No _____	Who _____
Mental retardation	Yes _____	No _____	Who _____
Hyperactivity	Yes _____	No _____	Who _____
Learning problems	Yes _____	No _____	Who _____
Reading or spelling difficulties	Yes _____	No _____	Who _____
Speech or language problems	Yes _____	No _____	Who _____

Does any disease run in the family? Yes _____ No _____ If yes, what? _____
_____

MEDICATION HISTORY:

List any medications your child is currently taking (including dosage and reason):_____
_____

List any medications that your child has taken in the past for more than a month (including dosage and reason): _____
_____

Has your child ever had a bad reaction to any medication? Yes ___ No ___ If yes, describe.
_____

SCHOOL HISTORY:

Does your child like school? Yes _____ No _____
Did your child attend nursery school or a preschool program? Yes _____ No _____
If yes, age started _____. Were there any problems? Yes _____ No _____ If yes, describe:
_____
Did your child attend 1st grade? Yes _____ No _____ If yes, age started: _____
Were there any problems? Yes _____ No _____ If yes, describe: _____
_____
Has the school currently reported problems with:

Reading	_____	Spelling	_____	Following directions	_____
Arithmetic	_____	Behavior	_____	Social adjustment	_____
Attention span	_____	Writing	_____		

Has any psychological testing been done at school? Yes ____ No _____
If so, where, when and by whom?_____
What recommendations were made? _____
_____
Has your child ever been held back or repeated a grade? If yes, which grade (s) and for what reason? _____
Does your child receive any special services in school (placement in special classroom, resource room, tutoring, remedial reading, OT, speech, reading services, etc.)? Yes _____ No _____ If yes, what services and for how long? _____
_____
If not now, has your child ever been in a special class or provided with special services under an IEP or 504? Yes ___ No ____ If yes, describe._____
_____
Have you obtained any academic help privately for your child? Yes _____ No _____ If yes, indicate what type, when, by whom and how often: _____
_____
What grades has your child mostly received in the past year? A's & B's ____ B's & C's _____
C's & D's ____ D's & F's ____ Outstanding ____ Good ____ Satisfactory ____ Improvement needed ____ Unsatisfactory ___
Are these grades changed from the previous years? Yes ___ No ___
In which subject does your child do best? _____ Have the most difficulty? _____
In the past year has your child been absent from school due to illness or injury?
Less than 2 weeks ___ 2-4 weeks ___ 5-8 weeks ___ Over 8 weeks ___
Briefly describe the reasons for your child's absence. _____

BEHAVIOR AND SOCIAL HISTORY:

Does your child have difficulty getting along with children his/her own age? Yes ____No _____
Does your child have difficulty getting along with adults? Yes ____ No ____
Does your child have problems making friends in school? Yes ___ No ___
Does your child have problems getting along with teachers? Yes ___ No ___
Does your child tend to get sick in the morning before school? Yes ___ No ___
Does your child get disciplined frequently at school? Yes ___ No ___
How does your child occupy his/her time? _____
_____
How does your child perform athletically? _____
Has your child had emotional, adjustment, or behavioral problems? Yes _____ No _____
Has your child received any psychological or psychiatric treatment? Yes _____ No _____
If yes, when, where and by whom? _____
_____

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In addition to this history form, the additional information which was requested during the initial telephone conversation would also be helpful. This includes your child's birth and medical records if relevant; and preschool and/or school records, including evaluation reports by school personnel. If your child has had any evaluations outside of the school, we would appreciate copies of those, as well.

Additional comments: