Atlanta Neuropsychological Services
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PEDIATRIC NEUROPSYCHOLOGY PATIENT HISTORY FORM

Confidential

NOTE: This information is intended to help us gather information we need to help your child. Everything is confidential and will not be released without your permission. Please **bring it with you to your appointment** or **email to**: (jondodd@atlneurosvc.com).

Child Demographics

Date Completed

Child's Name:	**Child's Date of Birth:**	**Child's Sex:** ☐ Female ☐ Male	**Gender Identity:** ☐ Female ☐ Male
Name of Person Completing Form:	**Relationship to Child:**	**Child's Handedness:** ☐ Right ☐ Left ☐ Ambidextrous ☐ Not Sure Yet	
Child/Parent's Address:		**Parent's Phone number(s)**	

Which of the following best describes your child:

☐ American Indian or Alaskan Native
☐ African American/Black
☐ White
☐ Other: _____
☐ Asian Indian; Chinese; Filipino; Japanese; Korean; Vietnamese; Other Asian
☐ Spanish/Hispanic/Latino: Mexican, Mexican American, Puerto Rican, Cuban
☐ Native Hawaiian; Guamanian or Chamorro; Samoan; Other Pacific Islander

Language(s) spoken at home:	**Caregiver/Parents' preferred language:**

Age at which child was first exposed to the English language:

Referred by (who suggested that your child have this evaluation)**:**

Reason for Referral and Parental Concerns (please describe in detail the problems that are affecting your child and family):

What is your expectation of today's visit?

Do you have any specific questions you're hoping the Neuropsychologist will answer today?

FAMILY HISTORY

Caregiver 1: Name:_____ **Age**: _____

Relationship to Child:

☐ Biological Mother ☐ Biological Father ☐ Aunt/Uncle ☐ Step-Parent ☐ Adopted Parent
☐ Grandparent ☐ Legal Guardian ☐ Sibling ☐ Foster Parent ☐ Other: _____

Education: ☐ less than high school ☐ High School diploma or GED ☐ Associate's / technical degree (2-yr degree)
☐ Some college (# of years? ___) ☐ College Degree (4-yr degree) ☐ Postgraduate degree: _____

Occupation: _____

Caregiver 2: Name:_____ **Age**: _____

Relationship to Child:

☐ Biological Mother ☐ Biological Father ☐ Aunt/Uncle ☐ Step-Parent ☐ Adopted Parent
☐ Grandparent ☐ Legal Guardian ☐ Sibling ☐ Foster Parent ☐ Other: _____

Education: ☐ less than high school ☐ High School diploma or GED ☐ Associate's / technical degree (2-yr degree)
☐ Some college (# of years? ___) ☐ College Degree (4-yr degree) ☐ Postgraduate degree: _____

Occupation: _____

Parents or Caregivers are: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed

Siblings:

		Full Sibling	Half Sibling	Step Sibling
Name _____ Age _____ Grade _____	☐	☐	☐	
Name _____ Age _____ Grade _____	☐	☐	☐	
Name _____ Age _____ Grade _____	☐	☐	☐	

Child lives with:

Have YOU or ANYONE in your *immediate or extended family* experienced the following (besides your child)**:**

			Family Member
Speech or language problems	☐ Yes	☐ No	_____
Attention-deficit/Hyperactivity Disorder (ADD/ADHD)	☐ Yes	☐ No	_____
Learning Disability / Learning problems	☐ Yes	☐ No	_____
Trouble learning to read	☐ Yes	☐ No	_____
Held back in school	☐ Yes	☐ No	_____
Mental retardation/ Intellectual disability	☐ Yes	☐ No	_____
Genetic disorder	☐ Yes	☐ No	_____
Depression	☐ Yes	☐ No	_____
Anxiety or panic attacks	☐ Yes	☐ No	_____
Bipolar disorder	☐ Yes	☐ No	_____
Seizures	☐ Yes	☐ No	_____
Autism Spectrum Disorder	☐ Yes	☐ No	_____
Alcohol or drug abuse	☐ Yes	☐ No	_____
Schizophrenia/ Psychosis	☐ Yes	☐ No	_____
Suicide or attempted suicide	☐ Yes	☐ No	

Pregnancy & Newborn History

Pregnancy & Delivery:

Length of Pregnancy (weeks): _____

Child's Birth Weight ____ pounds ____ ounces Delivery was by: ☐ Vaginal ☐ C-Section

Problems with pregnancy or delivery: ☐ Yes ☐ No

If yes, please explain:

Mother had to take prescription medications during pregnancy: ☐ Yes ☐ No

If yes, please list medication(s):

Mother's health during pregnancy (please check yes or no)**:**

Alcohol Use	☐ Yes	☐ No	Drug Use	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Serious Injury	☐ Yes	☐ No	Smoked Cigarettes	☐ Yes	☐ No	Twin/Multiple Birth	☐ Yes	☐ No

At birth, did your child:

Have trouble breathing	☐ Yes	☐ No	Turn blue (cyanosis)	☐ Yes	☐ No
Need oxygen	☐ Yes	☐ No	Turn yellow (jaundice)	☐ Yes	☐ No

Was your child adopted? ☐ Yes ☐ No **If applicable,** at what age? _____

Developmental History

How old was your child when he/she began to: (If unsure, please make your best guess).

Crawl: _____.

Walk without assistance: _____

Speak single words (e.g., "mamma, dadda, ball).": _____

String together 2-3 word phrases: _____

Speak in full sentences: _____

Did your child ever have problems with:			**If "yes," when did these problems emerge:**
Fine motor skills (e.g., tying shoes, handwriting)	☐ No	☐ Yes	_____
Speech (e.g., making clear speech sounds)	☐ No	☐ Yes	_____
Language (e.g., not producing enough words)	☐ No	☐ Yes	_____

Did your child ever participate in any type of Early Intervention Services: ☐ Yes ☐ No

If yes, at what age did your child begin services: _____

Has your child <u>EVER</u> received the following in the community or hospital setting? If "yes," then what age and reason?

☐ Audiology or Hearing Services	☐ No	☐ Yes	Age_____	Reason _____
☐ Speech/Language Therapy	☐ No	☐ Yes	Age_____	Reason _____
Occupational Therapy	☐ No	☐ Yes	Age_____	Reason _____
Physical Therapy	☐ No	☐ Yes	Age_____	Reason _____
Psychological Services:	☐ No	☐ Yes	Age_____	Reason _____

Medical History

Has your child ever experienced any of the following medical conditions?

(Please respond to every item below)

				Age/Year diagnosed or onset of problem
Feeding problems	☐ Past	☐ Present	☐ No concern	_____
Sleeping problems	☐ Past	☐ Present	☐ No concern	_____
Sensory Sensitivities (e.g., tags, textures)	☐ Past	☐ Present	☐ No concern	_____
Ear Infections	☐ Past	☐ Present	☐ No concern	_____
Ear Tubes	☐ Past	☐ Present	☐ No concern	_____
Hearing problems	☐ Past	☐ Present	☐ No concern	_____
Need hearing aids	☐ Past	☐ Present	☐ No concern	_____
Visual Problems	☐ Past	☐ Present	☐ No concern	_____
Wear glasses/contacts	☐ Past	☐ Present	☐ No concern	_____
Frequent/severe headaches	☐ Past	☐ Present	☐ No concern	_____
Frequent stomach pain/nausea/vomiting	☐ Past	☐ Present	☐ No concern	_____
Asthma	☐ Past	☐ Present	☐ No concern	_____
Head Injury / Concussion	☐ Past	☐ Present	☐ No concern	_____
Seizures	☐ Past	☐ Present	☐ No concern	_____
Encephalitis	☐ Past	☐ Present	☐ No concern	_____
Meningitis	☐ Past	☐ Present	☐ No concern	_____
Surgeries	☐ Past	☐ Present	☐ No concern	_____

Other conditions (please explain):

Has your child undergone the following:

Neuropsychological/Psychoeducational evaluation	☐ Yes	☐ No
Electroencephalogram (EEG)	☐ Yes	☐ No
Scans of the Brain (CT, MRI)	☐ Yes	☐ No
Psychiatric Evaluation	☐ Yes	☐ No
Genetics Evaluation	☐ Yes	☐ No

Pediatrician's Name, Practice, phone number:

Is your child seen by medical specialist(s)? Check all that apply:

☐ Cardiologist	☐ Hem/Onc	☐ Neurologist	☐ Psychiatry	☐ Rehab/Physiatrist
☐ Gastronitestinal	☐ Hepatologist	☐ Neurosurgeon	☐ Psychologist/Counselor	☐ Sports Medicine
☐ Geneticist	☐ Endocrinology	☐ Orthopedics	☐ Pulmonology	☐ Ear, Nose & Throat

Drug Allergies? **Type of reaction?** ☐ anaphylaxis ☐ hives/rash ☐ breathing difficulties ☐ Other

CURRENT MEDICATIONS:

Name of Medication	Dosage	Frequency	Prescribing Physician	Is it helpful?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

PREVIOUS MEDICATIONS (no longer taking):

Name of Medication	Prescribing Physician	Side-effects (if any)	Reason for discontinuing this medication

Educational History

Name of Current School: _____ County: _____

Current Grade: _____ ☐ Public ☐ Private

Has your child ever repeated a grade? ☐ Yes ☐ No If "yes", what grade(s) and why? _____

Typical academic performance: ☐ straight A's ☐ A's – B's ☐ A's, B's, and C's ☐ B's – C's ☐ C's – D's ☐ D's – F's

Which subjects are harder for your child?_____.

What subjects come easier for your child? _____

Does your child have an Individualized Education Program (IEP) ☐ Yes ☐ No

Eligibility Classification for the IEP (please check all that apply):

☐ Other Health Impaired ☐ Autism ☐ Emotional and Behavioral Disorder

☐ Traumatic Brain Injury ☐ Deaf/Hard of Hearing ☐ Speech & Language Impairment

☐ Intellectual Disability ☐ Specific Learning Disability ☐ Significant Developmental Delay

☐ Visual Impairment ☐ Orthopedic Impairment

Does your child receive English as a Second Language (ESL) services? ☐ Yes ☐ No

Does your child have a 504 Plan? ☐ Yes ☐ No

Does your child have a Student Support Team (SST) and / or Response to Intervention (RTI) Process? ☐ Yes ☐ No

Has your child ever been suspended or expelled from school? ☐ No ☐ Yes If "yes", please explain

Psychosocial History

Does your child have a history of:

Formal Diagnosis or Problem	No	I have concerns, but never formally diagnosed	Yes. Formally diagnosed	Year diagnosed	Currently receiving treatment?
Attention problems / ADHD	☐	☐	☐		☐ Y ☐ N
Learning disability	☐	☐	☐		☐ Y ☐ N
Depression	☐	☐	☐		☐ Y ☐ N
Anxiety / Worries	☐	☐	☐		☐ Y ☐ N
Bipolar Disorder	☐	☐	☐		☐ Y ☐ N
Posttraumatic stress disorder	☐	☐	☐		☐ Y ☐ N
Oppositional Defiant Disorder	☐	☐	☐		☐ Y ☐ N
Conduct Disorder	☐	☐	☐		☐ Y ☐ N
Autism Spectrum Disorder	☐	☐	☐		☐ Y ☐ N
Schizophrenia / Psychosis	☐	☐	☐		☐ Y ☐ N
Suicidal Ideation, self-harm, or attempts	☐	☐	☐		☐ Y ☐ N
Eating disorder	☐	☐	☐		☐ Y ☐ N
Drug and/or alcohol use or abuse	☐	☐	☐		☐ Y ☐ N
Legal problems	☐	☐	☐		☐ Y ☐ N
Abuse or neglect	☐	☐	☐		☐ Y ☐ N
Other:	☐	☐	☐		☐ Y ☐ N

Has your child ever received any of the following forms of psychological treatment:

Individual counseling / therapy	☐ Past	☐ Present	☐ Never
Group therapy	☐ Past	☐ Present	☐ Never
Family therapy	☐ Past	☐ Present	☐ Never
Inpatient psychiatric treatment	☐ Past	☐ Present	☐ Never
Psychiatric medications	☐ Past	☐ Present	☐ Never

Please list your child's play interests, hobbies, or extracurricular activities:

Please list organizations that your child belongs to (e.g., Girl Scouts, Boy Scouts, 4H, Soccer, etc.)

Please list your child's strengths:

Please list your child's weaknesses: