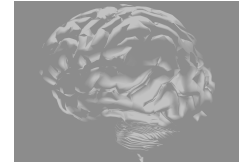


Pediatric Neuropsychological History



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By having as much information as possible, we will be better able to develop a more accurate understanding of your child's development and behavior. Developmental history is important in diagnosing and understanding developmental and behavioral problems, learning disabilities, or the effects of neurologic injury. There are often clues in the history that help us recognize problems that allow us recommend treatment approaches.

Please complete this in as much detail as you can. This will help save time and expense. You may find it helpful to consult baby books, medical records or other sources of information. Please bring in previous scores and testing that your child may have, including school testing.

Thank you for filling out this questionnaire before the consultation. This will help us provide the best care for your child. A brief description of the evaluation and map can be found at <http://www.medicalneuropsych.com>

Child's Name _____

Date Completed _____

Parent Completing Form _____

Child's Age _____ **Birth Date** _____

Gender M F **Hand (Writing)** R L

Primary Language _____ **Secondary Language** _____

Ethnic or Racial Background _____

BIRTH AND DEVELOPMENTAL HISTORY

You were born: On time ____ Prematurely ____ Late ____

Your weight at birth: ____ lbs. ____ oz.

Mother's weight gain during pregnancy: ____ lbs.

Were there any complications associated with your birth (e.g. oxygen deprivation, unusual birth position, etc.) or the period immediately afterward (e.g., need for oxygen, special equipment used, convulsions, illness, etc.)?

Yes ____ No ____

If yes, please describe: _____

Check all that applied to your mother while she was pregnant with you:

____ Accident

____ Alcohol use

____ Cigarette smoking

____ Drug use (marijuana, amphetamine, cocaine, LSD etc.)

____ Illness (toxemia, diabetes, high blood pressure, Rh incompatibility, etc.)

____ Poor nutrition

____ Psychological problems

____ Other problems: _____

List all medications (prescribed or over-the-counter) your mother took while pregnant:

During her pregnancy, did your mother live near a polluted area (e.g. toxic waste dump) or other hazardous area (e.g. nuclear plant, industrial area, pesticide sprayed area, etc.)?

Yes ____ No ____

If yes, please describe: _____

To your knowledge, when did you develop the following skills:

	Early	Average	Late
Walking	_____	_____	_____
Language	_____	_____	_____
Toilet Training	_____	_____	_____
Overall development	_____	_____	_____

As a child, did you have any of these problems? (Check all that apply.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Attention problems | <input type="checkbox"/> Head injury | <input type="checkbox"/> Muscle tightness or weakness |
| <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Learning disability | |
| <input type="checkbox"/> Other problems: _____ | | |

MEDICAL HISTORY

Childhood Medical History

Check all of the conditions you experienced as a child. Please add details (e.g. age of onset, treatment, etc.):

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fevers (104° F or higher) | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Brain infection or disease | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Immune system disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Lung (respiratory) disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Colds (excessive) | <input type="checkbox"/> Measles | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Oxygen deprivation | |
| <input type="checkbox"/> Other diseases or disabilities: _____ | | |
-

As a child, were you exposed to excessive amounts of lead (e.g. eating paint chips, living next to high concentrations of automotive exhaust fumes, etc.)?

Yes ____ No ____

If yes, please describe: _____

As a child, did you have an accident, which required a hospital visit?

Yes ____ No ____

If yes, please describe: _____

Did you ever suffer a serious injury to your head?

Yes ____ No ____

If yes, explain the circumstances and any problems you had afterwards: _____

How would you describe your nutrition as a child and adolescent?

Excellent ____ Average ____ Poor ____

List the medications that were regularly given to you as a child:

Medication	Reason For Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Adult Medical History

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hazardous substance exposure | <input type="checkbox"/> Oxygen deprivation |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Arteriosclerosis (artery disease) | <input type="checkbox"/> Huntington's Disease | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Brain infection or disease | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Radiation exposure |
| <input type="checkbox"/> Cancer or chemotherapy | <input type="checkbox"/> Lung (respiratory) disease | <input type="checkbox"/> Senility (Dementia) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Stroke or TIA) |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Other diseases or disabilities: | _____ | |
-

As an adult, did you have an accident, which required a hospital visit?

Yes No

If yes, please describe: _____

Did you ever suffer a serious injury to your head?

Yes No

If yes, explain the circumstances and any problems you had afterwards: _____

List any prescription or over-the-counter medications you are currently taking and the dosages:

	Name	Dosage	Reason
a)	_____	_____	_____
b)	_____	_____	_____
c)	_____	_____	_____
d)	_____	_____	_____
e)	_____	_____	_____
f)	_____	_____	_____

Do you have epilepsy or a seizure disorder? Yes No

If yes, check the one the appropriate type:

PARTIAL

GENERALIZED

UNCLASSIFIED _____

- Simple partial (Jacksonian)
- Complex partial (Psychomotor)
- Partial evolving into generalized
- Absence (Petit mal)
- Myoclonic
- Clonic
- Tonic
- Tonic-clonic (Grand mal)
- Atonic

I have a seizure disorder, but I don't know which type.

Please describe it: _____

Have you had a prior psychological or neuropsychological evaluation? Yes No

Psychologist _____

Address _____

Date and reason for evaluation _____

Findings _____

Check all medical procedures that have been done:

	Check if Normal	Date	Abnormal Findings
<input type="checkbox"/> Angiogram	<input type="checkbox"/>	_____	_____
<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"/> Lumbar Puncture or spinal Tap	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> MRI	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Neurological Examination	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> PET Scan	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> SPECT	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Physical Examination	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Skull x-ray	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Ultrasound	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Other Tests	<input type="checkbox"/>	_____	_____

FAMILY HISTORY

Mother

What is your mother's name? (include maiden name) _____

Is she alive? Yes ____ No ____

If deceased, what was the cause of death? _____

Mother's occupation: _____

Mother's level of education: _____

Mother's hobbies: _____

Does your mother have a known or suspected learning disability? Yes ____ No ____

If yes, describe: _____

Briefly describe your mother's health history: _____

Father

What is your father's name? _____

Is he alive? Yes ____ No ____

If deceased, what was the cause of death? _____

Father's occupation: _____

Father's level of education: _____

Father's hobbies: _____

Does your father have a known or suspected learning disability? Yes ____ No ____

If yes, describe: _____

Briefly describe your father's health history: _____

When you were born, what was your mother's age? ____ Father's age ____

How many brothers and sisters do you have? ____

Where are you in the birth order? ____

Are there any unusual problems (physical, academic, psychological) associated with any of your brothers or sisters?

Yes ____ No ____

If yes, describe: _____

Who raised you?

____ Biological parents ____ Relatives ____ Foster parents

____ Biological mother ____ Adoptive parents ____ Institutional setting

- ___ Biological father
- ___ Biological parent plus other person
- ___ Others: who? _____

What languages were spoken in your home when you were a child?

- 1) _____
primary language
- 2) _____
secondary language

Please check all the conditions that existed in close biological family members (parents, brothers, sisters, grandparents, aunts, uncles), note who it was, and describe the problem where indicated.

	Who	Describe
<u>Neurologic (brain) diseases</u>		
___ Alzheimer's disease or senility	_____	
___ Huntington's disease	_____	
___ Multiple sclerosis	_____	
___ Parkinson's disease	_____	
___ Other neurologic disease	_____	_____
<u>Psychiatric illness</u>		
___ Alcoholism	_____	
___ Bipolar illness (manic-depression)	_____	
___ Depression	_____	
___ Personality disorder	_____	
___ Schizophrenia	_____	
___ Other psychiatric illness	_____	_____
___ Epilepsy or seizures	_____	
___ Learning disability	_____	
___ Left-handedness	_____	
___ Mental retardation	_____	
___ Speech or language disorder	_____	
___ Other major disease or disorder	_____	_____

PERSONAL HISTORY

Marital History

Current marital status: Married ___ Single ___ Divorced ___

Widowed ___ Separated _____

Years married to current spouse: _____

Number of times married: _____

Spouse's name: _____ Spouse's age: _____

Spouse's occupation: _____

Spouse's health: Excellent ___ Good ___ Poor ___

Not married, but living with partner: Yes ___ No ___ His/her age: _____

His/her health: Excellent ___ Good ___ Poor ___

His/her occupation: _____

Children

Name	Age	General Health and Behavior
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who currently resides with you? _____

EDUCATIONAL HISTORY

Highest grade or degree earned: _____ Field: _____

Grades achieved (with any additional comments):

___ A & B _____

___ B & C _____

___ C & D _____

___ D & F _____

Best subject _____ Worst subject _____

Did you ever repeat or skip a grade? Yes ___ No ___

Comments: _____

Did you ever receive special (remedial) classes or tutors? Yes ___ No ___

Comments: _____

OCCUPATIONAL HISTORY

Current occupation: _____

How long have you had this job? _____

Job responsibilities: _____

	Prior Jobs	Responsibilities	Time on Job
a)	_____	_____	_____
b)	_____	_____	_____
c)	_____	_____	_____

At any time on a job, were you exposed to toxic, hazardous, noxious, or otherwise dangerous or unusual substances (e.g., lead, mercury, radiation, solvents, pesticides, chemicals, etc)?

Yes _____ No _____

If yes, explain: _____

MILITARY HISTORY

Branch: _____

Discharge rank: _____ Type of Discharge: _____

Major duties: _____

Did you sustain any physical injuries in the military? Yes _____ No _____

If yes, describe: _____

Were you exposed to any dangerous or unusual substances during your service (e.g., Agent Orange, radiation, etc.)?

If yes, describe: _____

RECREATION & DAILY LIVING

What types of recreation do you enjoy: _____

Do you currently need help with daily activities (i.e. dressing, cooking, driving)?

Yes _____ No _____

Comments: _____

SUBSTANCE USE HISTORY

Alcohol

I started drinking regularly at age:

Less than 10 years old _____ 10-15 _____ 16-18 _____ 19-20 _____ 21 or over _____

I drink alcohol:

rarely or never _____ 1-2 days/week _____ 3-5 days/week _____ Daily _____

I used to drink but have I stopped on: (date) _____

Preferred type(s) of drinks: _____

Usual number of drinks I have at a time: _____

My last drink was: less than 24 hours ago _____ 24-48 hours ago _____ Over 48 hours ago _____

Check all that apply:

_____ I can drink more than most people my age and size before I get drunk.

_____ I sometimes get into trouble (fights, difficulty, problems at work, conflicts with family, accidents, etc.) after drinking.

_____ I sometimes blackout after drinking.

_____ I have had a seizure after drinking.

_____ I have missed work or social engagements because of my drinking.

_____ I have been arrested for DUI.

_____ I have experienced the DT's after I stopped drinking.

_____ I have been in treatment to quit drinking.

Please explain: _____

Tobacco

I started smoking regularly at age:

Less than 10 years old _____ 10-15 _____ 16-18 _____ 19-20 _____ 21 or over _____

How many cigarettes do you smoke daily? _____

Drugs

Please check all the drugs you are now using or have used in the past:

	Presently Using	Used in past
_____ Amphetamines (including diet pills)	_____	_____

Name and Location of Neuropsychologist

Dates

LEGAL

Is the evaluation part of ongoing or pending litigation?

Yes _____ No _____

Have you spoken to an attorney about this evaluation?

Yes _____ No _____

Do you have ongoing or pending civil or criminal legal proceedings?

Yes _____ No _____

Name, location, and phone number of attorney:
