Child Neurodevelopmental History Form

Child's First Name ________________________ Child's Last Name ______________________________________

Sex ______ Birth Date ____/____/______ Current Age _______ Current Grade _______

Place of Birth ______________________________ Where did child grow up? ________________________________

School ______________________________ District ____

Home Address _________________________________ City ________________ State_____ Zip ___________

Home Phone (____)_____-_________

Birth Mother: Name ____________________________________ Age: _________

Home Address _________________________________ City ________________ State_____ Zip ___________

Phone (____)_____-_________

Birth Father: Name ____________________________________ Age: _________

Home Address _________________________________ City ________________ State_____ Zip ___________

Phone (____)_____-_________

Child is Presently Living With: (ages)

☐ Natural Parents ☐ Father (________) ☐ Mother (_______) ☐ Father/Step-mother (_____/_____)

☐ Adoptive Parents (____/____) ☐ Mother/Step-father (_____/_____) ☐ Other ___________ (_____/_____)

Referred By ____

Address ____ Phone (____) ______-_____________

Reason for Referral: ____

____

____

Is an attorney involved in this case? ☐ Yes ☐ No Name ________________________ Phone ______________

If your attorney has not requested an independent examination, we will only be responding to the referral questions of your referring clinician. We might not address specific medico-legal questions your attorney may have. If you have any questions about this issue, you should contact your attorney.

Do you want a copy of your report sent to your attorney? ☐ Yes ☐ No

Is there a guardian for the patient? ☐ Yes ☐ No a conservator? ☐ Yes ☐ No

	Name of School	Year graduated	Degree	Major
High school				
2 yr College				
University				
Post-graduate study				
Post-graduate study				

Current Medications:

____

____

____

I. PREGNANCY AND DELIVERY

Pregnancy

Duration of pregnancy (weeks) _________ *(full-term is 40 weeks)*

Check any of the following problems that occurred during your pregnancy:

☐ Excessive vomiting Explanations:
☐ Threatened miscarriage
☐ Spotting/Bleeding
☐ Infections
☐ Toxic Exposure
☐ Trauma (physical/mental)
☐ RH incompatibility
☐ Diabetes
☐ Toxemia
☐ High Blood Pressure
☐ Anemia
☐ Physical Injury
☐ Drinking (how much? ___________)
☐ Smoking (how much? ___________)
☐ Drug Abuse (which drugs? ___________)

Surgeries during pregnancy? ☐ Yes ☐ No *Please specify:*____
____
Illness during pregnancy:____
Medications taken during pregnancy:____
Other significant events, complications, or diagnostic procedures? *Please explain:*____
____

Delivery
Labor: ☐ Spontaneous ☐ Induced ☐ Duration (hours) _________
Delivery: ☐Vaginal ☐ Breech ☐ C-Section
Apgar Scores (if known) __________ Birth Weight: _____ pounds _____ ounces

Complications: ☐ Cord around neck ☐ Hemorrhage ☐ Cyanosis
☐ Forceps ☐ Bruising ☐ Lack of oxygen ☐ Birth Injury ______________________________
☐ Required oxygen ☐ Transfusions ☐ Treatment required for jaundice

Infection? *(Please explain)* ____
Other complications: ____
Specialized care (incubator, oxygen, etc.) ____
Number of days infant was in the hospital after delivery ____________________

Did your baby have:
☐ Problems sucking ☐ Problems growing ☐ Excessive sleep
☐ Problems swallowing ☐ Unusual stiffness ☐ Milk allergies
☐ Feeding problems ☐ Problems sleeping ☐ Other allergies
☐ Other ____

Describe your baby's behavior, mood, and temperament for the first 18-25 months ________________________
____
____

II. DEVELOPMENTAL PROGRESSION
Developmental Milestones (Be precise)
Age achieved:

1. _____ Rolled over? 2. _____ Sat up? 3. _____ First words? 4. _____ Sentences?
5. _____ Bladder trained (day)? 6. _____ Bladder trained (night)? 7. _____ Bowel trained?
8. _____ Walked?

Were any of the following present to an unusual degree during the **<u>first six years</u>** of life?
Please check those that apply and explain as necessary:

☐ Allergies Explanations:
☐ Ear infections
☐ Tubes (i.e., for ear infections)
☐ Eating problems
☐ Drooling
☐ High fevers
☐ Headaches
☐ Poisoning/toxic exposure
☐ Poor weight gain
☐ Lethargic
☐ Colic
☐ Head banging
☐ Clumsy, uncoordinated
☐ Unusual number of accidents
☐ Restless
☐ Disrupted sleep
☐ Not calmed easily
☐ Did or does not like to be held
☐ Difficult to console
☐ Masturbation
☐ Irritability
☐ Unresponsive
☐ Aggressive
☐ Thumb sucking
☐ Nightmares
☐ Easily Agitated
☐ Unusual active
☐ Into everything, climbing
☐ Other _________________________

Is your child: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous
When did handedness become evident? ________________________________
Has your child ever changed handedness? ☐ Yes ☐ No
Family history of left-handedness? ☐ Yes ☐ No
Did your child enjoy drawing and/or coloring as a toddler/preschooler? ☐ Yes ☐ No *Please explain:* __________
____

Were there any areas of your child's development that were of concern to you between birth and the beginning of school? ☐ Yes ☐ No *Please explain:*____
____

At what point did you become concerned about this child's development and/or behavior? ____________________
____

Have any siblings experienced problems of development/mastery of skills for their age? ☐ Yes ☐ No
*Please explain:*________________________________ ______________________________
____

All children exhibit, to some degree, the behaviors listed below. Check those that you believe your child exhibits to an **excessive** or **exaggerated** degree compared to siblings or other children of the same age:

Behavioral:
☐ Tics/Twitching
☐ Sloppy table manners
☐ More aggressive than siblings
☐ Talks around issue; can't come to a point
☐ Avoids reading
☐ Does not respond to discipline
☐ Interrupts frequently
☐ Problems understanding jokes
☐ Sudden acts of aggression
☐ Problems finding the right word
☐ Heedless of danger
☐ Nail-biting
☐ Acts as if "driven by a motor"
☐ Excessive swearing
☐ Temper outbursts
☐ Depression
☐ A "different child"
☐ Social Withdrawal
☐ Excessive number of accidents

Cognitive:
☐ Problem expressing emotion
☐ Hyperactivity
☐ Poor consequences of behavior
☐ Sleep walking
☐ Does not learn from consequences
☐ Does not listen
☐ Problems changing from one activity to another
☐ Anxiety
☐ Does not learn from experience
☐ Impulsivity
☐ Gets lost easily
☐ Clumsy
☐ Poor memory
☐ Does not think logically
☐ Asks to have repeated what has been said
☐ Poor awareness of time
☐ Poor attention span
☐ Problems expressing thoughts or ideas
☐ Difficulty finishing tasks
☐ Disorganization
☐ Difficulty listening

Does your child seek out friends? Always 1 2 3 4 Never
Do other children seek your child out? Always 1 2 3 4 Never
Does your child relate well to other children? Always 1 2 3 4 Never

Are friends: ☐ older ☐ younger ☐ same age

Problems with friendships? ☐ Yes ☐ No Explain:____
Is not well liked by peers? ☐ Yes ☐ No Explain:____
Different from peers? ☐ Yes ☐ No Explain:____
Briefly describe any problems with peers ____
____

Types of discipline you use or have used with your child: ______________________________________
____
Is discipline effective? Please explain ____
____

What are your child's areas of greatest accomplishments? ______________________________________
____
What does your child enjoy doing most? ____
____
What does your child dislike doing the most? ____
____
Does your child participate in sports activities? ☐ Yes ☐ No
Which sports? ______________________________

Is your child experiencing any of the following problems:

☐ Drugs/substance abuse	☐ Depression	☐ Suicidal threats or gestures
☐ Alcohol	☐ Trouble with the law	☐ History of sexual abuse (victim)
☐ Sexually active	☐ Violent behavior	☐ History of sexual abuse (perpetrator)

Physical development progressing without complication? ☐ Yes ☐ No
Age of first pubertal development __________ Date of first menstrual period _________
Complications, if any ____

Is your child dating? ☐ Yes ☐ No Frequency ______________________________

What is your relationship with your child? ____
____

III. FAMILY HISTORY

Biological Mother ____________________________________ Age _______________

Education:
Highest grade completed _______ (1-12) High school graduate/GED (circle)
Number of college credit hours completed _______
Highest degree awarded____
Vocational Training ______________________________ Years ____________
Current employment/occupation ______________________ Hrs/Wk ___________
Business name ____
Learning problems ____
Behavioral problems/Psychiatric disorder _______________________________
Medical problems ____
Have any of your child's other blood relatives experienced problems similar to those your child is currently experiencing? Is so, please describe ______________________________
____

Biological Father ______________________________________ Age _________________

Education:

Highest grade completed _______ (1-12) High school graduate/GED (circle)

Number of college credit hours completed _______

Highest degree awarded____

Vocational Training _______________________________ Years ____________

Current employment/occupation _____________________ Hrs/Wk ___________

Business name ____

Learning problems ____

Behavioral problems/Psychiatric disorder _________________________________

Medical problems ____

Have any of your child's other blood relatives experienced problems similar to those your child is currently experiencing? Is so, please describe ____
____

Children in the family (use back if necessary)

Name	Age	Medical, Social or School Problems

Which siblings are currently living with this child: ____

Many developmental/behavioral problems are passed on genetically. Often, other family members may have similar problems. Understanding family history often helps the diagnostic process. Is there any history of the following:

Check all that apply:

Maternal:

- ☐ Learning problems
- ☐ School problems
- ☐ Attention/Concentration problems
- ☐ Hyperactivity
- ☐ Anxiety
- ☐ Obsessive Compulsive Disorder
- ☐ Unreasonable fears (phobias)
- ☐ Depression
- ☐ Suicide
- ☐ Alcoholism
- ☐ Drug abuse
- ☐ Psychiatric hospitalization
- ☐ Moodiness
- ☐ Other ______________________

Paternal:

- ☐ Learning problems
- ☐ School problems
- ☐ Attention/Concentration
- ☐ Hyperactivity
- ☐ Anxiety
- ☐ Obsessive Compulsive Disorder
- ☐ Unreasonable fears (phobias)
- ☐ Depression
- ☐ Suicide
- ☐ Alcoholism
- ☐ Drug abuse
- ☐ Psychiatric hospitalization
- ☐ Moodiness
- ☐ Other ______________________

IV. SCHOOL EXPERIENCE/LEARNING PROBLEMS

Did your child participate in programs? ☐ Yes ☐ No *Please explain:* ___________________________________

Rate your child's school experience relative to academic learning:

	Good	Average	Poor
Preschool			
Kindergarten			
Grade School			
Junior High			
High School			
College			
Current Grade			

Rate your child's school experiences relative to behavior.

	Good	Average	Poor
Preschool			
Kindergarten			
Grade School			
Junior High			
High School			
College			
Current Grade			

To the best of your knowledge, at what grade level is your child currently performing?

Reading _______ Spelling _______ Arithmetic _______

Has your child ever been retained for any reason or has retention ever been suggested? ☐ Yes ☐ No

Please explain: ____

Has your child ever been in resource or special education placement? ☐Yes ☐ No *If yes,please explain:*_______

____

Has your child ever been referred for special education consideration? ☐ Yes ☐ No *If yes, please explain:*_____

____

Does (or has) your child receive any specific academic support (i.e. tutoring, counseling)? ___________________

____

Do you spend what you consider to be an unusual degree of time doing homework with your child? ___________

At what point did academic problems become obvious? ____

Has your child's classroom teacher(s) reported any of the problems below?

☐ Attention/Concentration
☐ Peer problems
☐ Following directions
☐ Distractibility
☐ Social problems
☐ Academic problems
☐ Activity level
☐ Withdrawal
☐ Handwriting
☐ Hyperactivity
☐ Aggression
☐ Low energy
☐ Not turning in assignments
☐ Learning problems
☐ Behavior problems
☐ Poor memory
☐ Other ___________

Does your child participate in extra-curricular activities at school (i.e., sports, clubs)? If so, what are they?
____

Please list the schools that your child has attended:
Elementary School ___________________________________
Junior High (middle school) ___________________________________
High School ___________________________________

V. PRESENT MEDICAL STATUS

Eye Color_________________________ Hair Color _________________________

Height __________________________ Weight _________________________

Medications your child has taken for an extended period of time ___________________________________
____

Current medical problems for which your child is being treated ___________________________________
____

Do you have any concerns for your child's ability to hear? ☐ Yes ☐ No
Hearing tested? ________ Hearing aids required? ☐ Yes ☐ No
Date
Do you have any concerns about your child's ability to see? ☐ Yes ☐ No
Vision tested? ________ Corrective lenses? ☐ Yes ☐ No
Date

Has your child ever had a seizure(s)? ________with fever? ________without fever?
Has your child experienced any head injury or concussion? Please explain ______________________________
____

Loss of consciousness? ____
____

Other major illnesses or injuries? ____
____

Surgeries? ____
Hospitalization(s)? ____

Does your child still wet the bed? ☐ Yes ☐ No
Does your child still soil? ☐ Yes ☐ No *If yes, frequency:* ____________________

Specific health problems: (past or present)

☐ Frequent headaches
☐ Abnormal gait
☐ Vomiting, chronic
☐ Head injury
☐ Hyperactivity
☐ Diarrhea, chronic
☐ Visual difficulty
☐ Tremor
☐ Constipation
☐ Puffy eyelids
☐ Convulsions
☐ Nausea

☐ Prominent eyes
☐ Weakness
☐ Hearing problems
☐ Un-coordination
☐ Urinary frequency/urgency
☐ Hoarse cry
☐ Faint spells
☐ Excessive thirst
☐ Large tongue
☐ Joint or bone pains
☐ Painful urination

☐ Lump in neck
☐ Acne or skin infections
☐ Bedwetting
☐ Difficulty swallowing
☐ Dry, scaly skin
☐ Difficulty breathing
☐ Cold, mottled skin
☐ Weight loss
☐ Persistent cough
☐ Itching of skin
☐ Excessive weight gain

☐ Shortness of breath
☐ Stretch marks on skin
☐ Irritability
☐ Palpitation of the heart
☐ Excessive sweating
☐ Poor appetite
☐ Pallor
☐ Sluggishness (lethargy)
☐ Excessive appetite
☐ Coarse, dry hair
☐ Abdominal pain
☐ Excessive body hair
☐ Restlessness

VI. NEUROLOGICAL HISTORY

Complete this section only if your child has seen a neurologist or neurosurgeon for some diagnosed disease or injury (i.e., brain tumor, seizures, infectious disease of the brain, head injury).

Which of the following apply to your child (please check all that apply)

☐ Birth Injury
☐ Spinal cord injury
☐ Developmental disorder
☐ Brain tumor
☐ Seizures
☐ Endocrine problem
☐ Meningitis
☐ Cerebral palsy
☐ Encephalitis
☐ Head injury/concussion
☐ Traumatic brain injury
☐ Headaches

Age at initial diagnosis _______ Presenting complaint or symptoms:____________________________________
____
Diagnosis ____

Neurologists/neurosurgeons currently following your child:
____
____

Previous neurologists/neurosurgeons who have seen your child:
____
____

Does your child have motor problems? ☐ Yes ☐ No
Require braces, orthotics ☐ Yes ☐ No
Wheel chair ☐ Yes ☐ No

Diagnostic Procedures Completed:
☐ CT Scan (Date:__________________________)
☐ MRI Scan (Date__________________________)
☐ SPECT Scan (Date __________________________)
☐ PET Scan (Date __________________________)
☐ Spinal Tap (Date __________________________)
☐ EEG (Date __________________________)

Hospitalizations (Please include dates and reasons):____
____

Neurosurgical procedures? ☐ Yes ☐ No *If yes, please explain:*____
____

Please list <u>all</u> of the doctors, therapists, and other providers treating you right now.

Name	Specialty	Phone Numbers

Pediatrician/family physician ____

Has your child ever received any psychological or psychiatric treatment? ☐ Yes ☐ No
If yes, by whom and when: ____
____

To save time and expense, as well as to make a more precise diagnosis, it would be helpful to have copies of all previous evaluations. Please respond to the questions below and obtain copies of the reports to bring to the initial interview.

Psychological or developmental testing completed? When and by whom? _____________________________
____

Individual testing by the school? ☐ Yes ☐ No *If yes, by whom and when?* _______________________
____

If your child is of school age, please provide all group testing completed by the school (i.e., achievement tests such as SAT, ITBS, CAT, proficiency tests, GATB). The school must release to you upon request a copy of your child's school file and resources or special education file.

Please rate the amount of stress you are currently experiencing

	Little or none						Extreme	
At home:	1	2	3	4	5	6	7	NA
At work:	1	2	3	4	5	6	7	NA
With extended family:	1	2	3	4	5	6	7	NA
With friends:	1	2	3	4	5	6	7	NA
With neighbors:	1	2	3	4	5	6	7	NA

In addition to this history form, the additional information that 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 these, as well.

VIII. ADDITIONAL REMARKS

Please write any additional remarks you may wish regarding your child's behavior, learning problems or development.