Island NeuroPsychology
Child/Adolescent History Form

Date:		**Name of person completing form:**	
Childs's First Name:		**Child's Last Name:**	
Home Address:		**DOB:**	
City:		**Zip code:**	
Home Phone:		**Gender:**	
Mother's Name:		**Father's Name:**	
Education:		**Education:**	
Occupation:		**Occupation:**	
Work Number:		**Work Number:**	

Who made the referral? _____

Reason for referral. (Development, behavior, academic social, medical, etc)

_____

Child's strengths:

_____

Child's weaknesses:

Are there different views regarding nature or cause of problems between either family member, parents, teachers, etc.

_____

Previous diagnoses: _____ **Current diagnoses:** _____

PREGNANCY:

Was this child adopted? ☐ No ☐ Yes (skip to Early History Section)

If yes, what age and from where? _____

Age of mother at delivery? _____

Age of father at delivery? _____

Which of the mother's pregnancies? (1st, 2nd, etc.) _____

Condition of baby at birth? _____

How much did your child weigh at birth? _____

Length of pregnancy? _____

Did you have any of the following during pregnancy? _____

	Yes	No	If yes, Explanation
Injuries	☐	☐	
Anemia	☐	☐	
High Blood Pressure	☐	☐	
Swollen Ankles	☐	☐	
Kidney Disease	☐	☐	
Heart Disease	☐	☐	
German Measles	☐	☐	
Toxemia	☐	☐	
Staining	☐	☐	
Bleeding	☐	☐	
RH or other blood incompatibility	☐	☐	
Vomiting	☐	☐	
Virus	☐	☐	
Threatened miscarriage	☐	☐	
Early contractions	☐	☐	
Diabetes	☐	☐	
Thyroid Disease	☐	☐	
Other chronic illness (please describe)	☐	☐	
Medications	☐	☐	
Other complications	☐	☐	

During your pregnancy with this child, did you use any of the following?

	Yes	No	Amount
Alcohol			
Tobacco			
Marijuana			
Other drugs/medications			

BIRTH HISTORY:

	Yes	No	If yes, Explanation
Was the birth a caesarean section?			
Was labor induced?			
Labor more than 12 hours?			
Labor less than 2 hours?			
Difficult delivery?			
Put to sleep for delivery?			
Were you given medication during labor?			
Was anesthesia used during labor?			
Was this a multiple birth?			
Was the baby born head-first?			
Were forceps used during delivery?			
Did your baby have any breathing problems?			
Was your baby born with cord wrapped around neck?			
Did your baby cry quickly?			
Was the baby's color normal at birth?			
Was the baby's color blue at birth?			
Did your baby require incubation?			
Did your baby receive oxygen?			
Was the baby's color yellow at birth?			
Did your baby require phototherapy?			
Did your baby receive transfusions?			
Was your baby colicky?			
Did this baby have any feeding problems?			
Did the baby have difficulty sucking?			
Did the baby have difficulty chewing?			

(Birth history continued)	Yes	No	If yes, Explanation
Did the baby have difficulty swallowing?			
Did the baby drool past the age of 2 1/2?			
Was the baby normally active?			
Was the baby limp?			
Was the baby stiff?			
Did the baby show unusual trembling?			
Did the baby fail to grow normally?			
Did the baby fail to gain weight?			
Was this baby different in any way from brothers or sisters?			

INFANT:

	Yes	No	If yes, Explanation
Fussy			
Overly Sleepy			
Hard to rouse			
Social, smile, eye contact			
Respond to cuddling			

EARLY HISTORY:

At approximately what age did this child:

	Age (in months)
Crawl	
Sit alone	
Walk alone	
Use a spoon	
Speak 1st words	
Two to four word sentences	
Talk in complete sentences	
Become toilet trained for bladder day	
Become toilet trained for bladder night	
Become toilet trained bowel day	
Become toilet trained bowel night	
Separate easily from caregiver	
Dress independently	
Tie shoelaces	

COMPARED TO OTHER CHILDREN:

Did the child have any difficulties with:

Speech problems including talking and understanding? ☐ Yes ☐ No

If yes, please explain:

Is English the child's first language? ☐ Yes ☐ No

If no what is child's first language?

Is your child fluent in any other languages? ☐ Yes ☐ No

Problems with gross motor skills (walking, hopping, ridding bike, etc.) ☐ Yes ☐ No

If yes, please explain:

Problem with fine motor skills (buttons, zippers, shoelaces, drawing, etc.) ☐ Yes ☐ No

If yes, please explain:

Early school related skills (naming colors/shapes, saying alphabet, recognizing coins, etc.) ☐ Yes ☐ No

If yes, please explain.

Problems playing/socializing with other children? ☐ Yes ☐ No

If yes, please explain.

Does this child play with younger/older and same aged children? ☐ Yes ☐ No

Are there opportunities to play with same aged children? ☐ Yes ☐ No

Are there difficulties separating? ☐ Yes ☐ No

If yes, at what age?

MEDICAL HISTORY

Has your child had any of the following?

	Yes	No	Age	If yes, Explanation
Head Injury				
Headaches				
Constipation				
Loss of consciousness				
Meningitis				
Encephalitis				
Seizures				
High Fever				
Strep Throat				
Ear Infections				
Myringotomy tubes (tubes in ears)				
Vision Problems				
Hearing Problems				
Heart Disease				
Asthma				
Chicken Pox				
Mumps				
German Measles (rubella)				
Measles (rubeola)				
Lead Poisoning				
Rashes, skin issues				
Allergies				
Pneumonia				
Slow weight gain				
Surgery				
Anemia				
Serious illness				
Heart problems				
Kidney problems				
Sick after immunization				
Bowel problems				
Other serious illness:				

BEHAVIOR - Please place a check in the column that best describes your child.

	NOT AT ALL	JUST A LITTLE	PRETTY MUCH	VERY MUCH
Often fidgets or squirms				
Difficulty remaining seated				
Easily distracted				

Difficulty awaiting turn in groups				
Blurts our answers to questions				
Difficulty following directions				
Difficulty sustaining attention				
Often shifts from one uncompleted activity to another				
Difficulty playing quietly				
Often talks excessively				
Interrupts or intrudes on others				
Does not seem to listen				
Loses things necessary for tasks				
Engages in physically dangerous activity without considering consequences				

Is your child currently taking any medications? ____**yes** _____**no**

If Yes:

Medication	**Dosage**	**Dates**	**Reason**	**Prescribed by**

Has your child had any of the following tests?

	Yes	**No**	**Date**	**Result**
Eye Exam				
Vision Therapy				
Glasses or Contacts				
Hearing Test				
EEG				
MRI				
CT Scan				

Has your child ever been hospitalized? ____ Yes ____ No **If Yes:**

Reason for Hospitalization	**Age of Child**	**Length of Stay**

FAMILY MEDICAL HISTORY

Is there anyone in your immediate or extended family who has (or had) any of the following:

	Yes	No	If yes, who (relation to child)
Learning problems			
Sensory problems			
Hearing loss			
Vision loss			
Speech or language problems			
Academic problems (e.g., retention)			
Left handed or ambidextrous			
Muscular weakness			
Deformities			
Early death			
Brain damage, head injury			
Slow development			
Emotional disturbance			
Thyroid disease			
Kidney disease			
Childhood heart disease			
Neurological disease			
Seizures (epilepsy)			
Intellectual disability			
Neurological disease			
Seizures (epilepsy)			
Mental retardation			
Attentional problems			
Behavioral problems			
Alcohol/Substance Abuse			
Allergies			
Tic disorder			
Bipolar			
Depression			
Manic-Depression			
Anxiety Disorder			

Obsessive-Compulsive Disorder			
Other psychiatric problems			
Schizophrenia			
Diabetes			
Cancer			
High Blood Pressure			
Heart Disease			
Alzheimer's			
Dementia			
Other disease/health problem that runs in family			

SOCIAL AND BEHAVIORAL HISTORY

Does your child have any brothers or sisters? ____ Yes ____ No

Please list names and ages of siblings including half or step siblings:

Who lives with your child?

Are the parents:
____ Married
____ Separated Date: _____
____ Divorced Date: _____
____ Never married

Would you describe your child as:

	Yes	No	If yes, Explanation
Shy			
Well Behaved			
Impulsive			
Clumsy using hands			
Immature			
Stubborn			
More active than other children			
Distractible			
Rigid			
Inflexible			
Inattentive			
Clumsy walking			

Has your child received any psychological or psychiatric treatment? ____YES ____NO

If yes, please complete below:

Provider	Reason	Dates

How would you describe your child's personality?

What are your child's favorite toys, games, hobbies, interests?

How does your child get along with other children?

How does your child respond to frustrations?

How does your child show displeasure?

How does your child show happiness?

What are your child's chores and responsibilities?

What forms of discipline do you use with your child? Are any successful?

Does your child have or did your child ever have:

	Yes	No	If yes, Age and Description of problem
Temper tantrums			
Sleep problems			
Sleep with parents			
Nightmares			
Blank Spells			
Falling Spells			
Doesn't listen			
Sad or worried			
Suicidal ideation/attempts			
Self-injurious behaviors			
Problems adhering to a schedule			
Tolerate change, transitions			
Average Intelligence			
Poor Handwriting			
Head Banging			
Toe Walking			
Thumb Sucking			
Tics or Twitching			
Difficulty staying with an activity			
Bedwetting after age 5			
Eating paper, paint, etc.			
Emotional Problems			
Adjustment Problems			
Behavioral Problems			

SUBSTANCE USE

Has your child used or experimented with illegal substances? ____Yes ____No

If yes, what: _____

Alcohol? ____Yes ____No

SCHOOL HISTORY

At what age did your child begin school? _____
What grade is your child currently in? _____
What school does your child currently attend? _____
School Address: _____
What is(are) the name of your child's teacher(s)?

Please list all schools your child has attended:

Grade(s)	Name of School	Years Attended (i.e. 1996-1997)

Within the past year has the school reported problems with:

	Yes	No	Indicate nature of problem
Reading			
Spelling			
Writing			
Arithmetic			
Behavior			
Social Adjustment			
Attention Span			
Following Directions			

Does your child like school? ____Yes ____No

During the past school year, how many days of school did your child miss? _____
Briefly describe your child's school experiences with regard to academic performance:

What kinds of grades does your child typically earn?

Briefly describe your child's school experiences with regard to his/her behavior

If your child has had any difficulties in school (academic or behavioral), in which grade did these problems start?

Has your child:

	Yes	No	Grade(s)	Description
Been in accelerated classes or classes for the gifted?				
Been retained in any grade?				
Received tutoring?				
Received resource support?				
Been in a self-contained Special education classroom?				

Please specify any special education support your child currently is receiving:

Does your Child have a(n): _____ 504 _____ IEP

If yes, what does the plan include?

How does your child manage homework?

What does your child think of the teacher?

How far do you expect child to go in school?

Please list prior assessments/evaluations as well as copies:

Tyof Evaluation **Date** **Recommendation**

ADDITIONAL COMMENTS: