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Initial History Form – Children and Adolescents

General Information

Child's Name:_____ Today's Date: _____

Child's Date of Birth: _____ Child's Age: _____ ☐ Male ☐ Female

Person completing form: _____ Relationship to child: _____

Complete home address: _____

Home phone: _____ Work phone: _____Cell phone/other: _____

Child's primary physician, address, and phone: _____

Child's neurologist and/or neurosurgeon:_____

Referral Information

Who referred you for neuropsychological evaluation? _____

What are you hoping to gain from these services? _____

_____

What do you think is the major cause of this child's difficulties? _____

_____

Describe some of this child's strengths: _____

Describe some of this child's weaknesses: _____

Pregnancy and Birth History

Child is: ☐ biological ☐ adopted (at age _____) ☐ foster (at age _____)
Were you (or the biological mother if adopted/foster) under a doctor's care? ☐ No ☐ Yes
Number of previous: pregnancies _____ miscarriages _____

Circle any of the following health complications that occurred during the pregnancy and provide detail if able.

Fertility problems	Vaginal bleeding	Toxemia	High blood pressure
Gestational diabetes	Trauma	Fever/rash (e.g., flu, measles)	Emotional problems
Abnormal weight gain	Anemia	Excessive swelling	Excessive vomiting
Blood incompatibility	Smoking	Alcohol	Illicit drugs
Medications	Hospitalization(s)	X-ray/imaging _____	Other: _____

Medications, tobacco, alcohol, or other drugs during pregnancy:_____

Age of mother at delivery: _____ Age of father at delivery: _____ Age of mother at birth of first child: _____

Birth weight: _____ lbs. _____ oz. Length of pregnancy: _____ weeks Length of labor: _____ hours

Apgar scores: _____ Delivery was: ☐ vaginal ☐ Cesarean (reason: _____)

Note if any of these complications occurred during delivery/birth and provide details if known.

Breech position Cord around neck Meconium staining Lacking oxygen/hypoxic Forceps used
Labor induced Abnormal color_____ Phototherapy_____ Other:_____
Did baby breathe spontaneously? ☐ No ☐ Yes
Oxygen required? ☐ No ☐ Yes If yes, for how long? _____

Transfusion required? ☐ No ☐ Yes If yes, why and how many? _____

Length of stay in hospital: Mother: _____ days Child: _____ days

Medical problems after hospital discharge (e.g., jaundice, apnea, surgery)_____

Any problems in first few months? ☐ No ☐ Yes Explain: _____

Did mother experience postpartum (after birth) depression? ☐ No ☐ Yes _____

Describe this child's temperament as an infant: _____

Developmental History

Motor

Age sat alone: _____ crawled: _____ stood alone: _____ walked alone: _____

Slow to develop motor skills or awkward compared to siblings/friends?_____

Handedness: ☐ right ☐ left ☐ Ambidextrous/both Age established hand dominance _____

☐ History of physical therapy? Dates & reason_____

☐ History of occupational therapy? Dates & reason_____

Speech/Language

Age spoke first word: _____ expressed 2-3 word phrases: _____ spoke in structured sentences: _____

☐ Oral-motor problems (e.g., late drooling, poor sucking, poor chewing)? _____

☐ Speech delay/problems (e.g., stutters, difficult to understand)?_____

☐ History of speech/language therapy? Dates & reason_____

☐ Other language spoken in home (besides English)? _____

Toileting

Age trained for bladder_____ Age trained for bowels_____ Bed wetting?____ If yes, until age=_____

☐ Urine accidents during the day? Until age=_____ When/where did this occur? _____

☐ Soiling accidents? Until age=_____ When/where did this occur?_____

☐ Current wetting or soiling problems? Explain: _____

Medical History

Circle any of the following that apply. ***Indicate age of onset AND duration****.*

Failure to thrive	Febrile seizures	Diagnosed epilepsy	Staring spells	Lead poisoning
Toxic ingestion	Meningitis	Encephalitis	Asthma	Allergies
Diabetes	Loss of consciousness	Stomach pain	Vomiting	Headaches
Constipation	Urination problems	Accident prone	Frequent ear infections	Sleep problems
Eating problems	Tics/twitching	Repetitive movements	Impulsivity	Temper tantrums
Nail biting	Clumsiness	Head banging	Self-injurious behavior	Rocking back and forth

Has vision been checked? ☐ No ☐ Yes Any problems? _____

Has hearing been checked? ☐ No ☐ Yes Any problems? _____

History of ear tubes? ☐ No ☐ Yes If yes, when and how many sets? _____

Current medications and reasons: _____

_____

List any head injuries, concussions, serious illnesses, surgeries (etc.) **and age of occurrence**: _____

_____

If any of the following have been performed, list dates and results.

CT of brain/head _____

brain/stem MRI _____

EEG_____

MRA of head_____

SPECT or PET_____

MEG_____

Any other non-routine exams involving the brain/nervous system_____

Family History: **Please describe** any family history of the following problems. Indicate the relationship(s) to the child.
Learning disabilities, ADD/ADHD_____

Psychiatric/neurochemical (e.g., depression, anxiety, bipolar) _____

Alcoholism or substance abuse_____

Autism _____

Intellectual disability/delay_____

Neurological (e.g., Alzheimer's, Parkinson's, TBI, epilepsy)_____

Other (e.g., cancer, diabetes, migraines, cardiovascular/heart disease)_____

Anyone else in family have problems similar to this child's reason for referral? _____

Family Information

Mother's name: _____Age: _____Education: _____

Occupation: _____Employer: _____

Father's name: _____Age: _____Education: _____

Occupation: _____Employer: _____

Parents are: ☐ married ☐ separated ☐ divorced ☐ never married ☐ Other_____

Describe current relationship between parents (e.g., loving, friendly, civil, volatile)_____

Do parents generally agree on discipline/child rearing strategies? ☐ No ☐ Yes If no, explain_____

If divorced, list custody and visitation arrangements_____

List all siblings, step-parents, grandparents (etc.) in the household(s).

Age	Sex	Name/relationship to this child	Living at home?	Problems?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Is this child in a child-care setting besides school? ☐ No ☐ Yes How many hours/days? _____

Has this child experienced death of loved one or separation from loved one? ☐ No ☐ Yes If yes, explain:_____

_____

Social History and Adaptive Functioning

Does this child:

have difficulty relating to or playing with other children?	☐ No	☐ Yes
interact better with adults than children his/her own age?	☐ No	☐ Yes
have difficulty making/keeping friends?	☐ No	☐ Yes
understand social gestures?	☐ No	☐ Yes
have a good sense of humor?	☐ No	☐ Yes
understand social cues well (e.g., knows when others are angry)?	☐ No	☐ Yes
have problems with peer pressure or bullying?	☐ No	☐ Yes
show a desire to please you?	☐ No	☐ Yes
manage change in routine/expectation well?	☐ No	☐ Yes
require excessive prompting to complete chores/responsibilities?	☐ No	☐ Yes

When did you first become concerned about his/her social, emotional, behavioral functioning?_____

Psychological History

List previous direct contact with any psychologist (including evaluations), psychiatrist, or other behavioral specialist:

Name and type of professional	Reason for services	Date(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe this child's typical mood: _____

Academic History

Current school: _____ Current grade: _____

Classroom placement/supports: ☐ regular ☐ resource/special education ☐ other_____

Describe any accommodations currently received at school: _____

Any grades that were skipped or repeated? ☐ No ☐ Yes Explain: _____

Circle any of the following for which teachers have reported problems.

Reading Spelling Math Writing Attention/concentration Behavior/emotion Social adjustment

Describe any academic problems that occurred in:

Preschool _____

Kindergarten _____

Early elementary school (1st to 2nd) _____

Upper elementary school (3rd to 5th) _____

Middle school (6th to 8th) _____

High school _____

Additional Comments:_____

_____

_____

_____

_____

_____