PEDIATRIC NEUROPSYCHOLOGY SERVICES, PLLC
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Background Information Form

Child's Name:

Name of person filling out this questionnaire:

Reason you are requesting this evaluation

In my opinion, the major cause of my child's difficulties is

Describe some of your child's strengths

Describe some of your child's weaknesses

Do both parents agree about the nature and causes of the problem?

Has your child experienced death or separation from a loved one? Explain

Are there any significant family or marital conflicts? Explain

Pregnancy and Birth History

Age at delivery of mother ______ and father ______? How many prior pregnancies?______How many prior miscarriages? ______ Was a fertility specialist consulted? ______ Procedures? ____

Any known health problems of mother during pregnancy?
vaginal bleeding? _______ toxemia? ______hypertension?______
Gestational diabetes? ________ trauma? ________
fever/rash? (e.g., flu,measles?) _____antibiotics? ______
depression or other emotional problems? _____ blood incompatibility? injury? _____
other? ____

List any medications, tobacco use, alcohol use or drugs taken by mother during pregnancy____
Delivery was vaginal ______ Cesarean ______ (reason _________________________)

Baby was full term ______ or premature ______ (weeks gestation)

Birth Weight _____ lb. _____ oz.

Was labor prolonged?______(length of time =______)

Any birth complications? (e.g., feet first/cord around neck/meconium staining/lacking oxygen-blue/jaundice-yellow) _____

Did baby breathe spontaneously? ____oxygen required? _________

Apgar scores if known _______ In Intensive Care Nursery?___________

How old was baby at discharge from the hospital after birth? __________

Medical problems after discharge (e.g., jaundice, fever, transfusion, surgery) ________

Any problems in first few months? ____

Did you experience a postpartum (after birth) depression? _____________________

Developmental History

Motor

Approximate age sat alone _____crawled_____stood alone_____walked alone_____

Was your child slow to develop motor skills or awkward compared to siblings/friends (e.g., running, skipping, climbing, biking, playing ball?
____

Handedness: right ______ left ______ both ______ (explain)

Family history of left handedness (list relatives)?_____________________________

Was physical therapy ever necessary? (when?)______________________________

Was occupational therapy ever necessary? (when?) __________________________

Speech/Language

Age spoke first word ______ put 2—3 words together ___________

Speech delays/problems (e.g., stutters, difficult to understand)?______________
____

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

Was speech/language therapy ever necessary? ______________________________

Was child slow to learn the alphabet? ______ name colors? ______ count? ______

Other language spoken at home (besides English)?______________________________

Besides English my child is fluent in ____

Toileting

Age when toilet trained ____

Problems with bedwetting? urine accidents? soiling? Until what age?
____

Any current problem?____

Social Behavior

Does your child get along well with other children?_______adults? _________

have friends? _________keep friends? ________

understand gestures? _________have a good sense of humor? _________

understand social cues well (e.g., knows when others are angry, in discomfort)? _________have problems with peer pressure (e.g., alcohol or drug use) _____

Medical History

Has vision been checked? __Any problems:______________________________

Has hearing been checked? __ Any problems:______________________________

CT or MRI obtained? Results: ____

EEG obtained? Results: ____

List serious illnesses/injuries/hospitalizations/surgeries

date incident (explain)

_______ ____

_______ ____

_______ ____

Is there a history of:

failure-to-thrive? ____
febrile seizures? (fever associated) ____
epilepsy? ____
staring spells? ____
lead poisoning/toxic ingestion? ____
meningitis or encephalitis? ____
asthma or allergies? ____
diabetes? ____
loss of consciousness? ____
abdominal pains/vomiting? ____
when do they occur? ____
headaches? ____
when do they occur? ____
frequent ear infections? ____
were ear tubes necessary? ____
age when tubes placed____
sleep difficulties? ____
eating difficulties or eating disorder? ____
tics/twitching? ____
repetitive/stereotypic movements? ____
impulsivity? ____
temper tantrums? ____

nail biting? ____
clumsiness? ____
head banging?____
self-injurious behavior?____

Describe head injuries: (e.g., date, type, loss of consciousness?, resulting changes in behavior?)____

Is there a history of learning difficulty in any family member?

Is there a history of neurological illness in any family member?

Is there a history of seizures in any family member?

Is there a family history of psychiatric disorder?

Does anyone else in the family have a problem similar to your child's reason for referral?

Educational History

Current school:____

Grade: ________ Placement: regular __ resource __special education __

Any grades that were skipped or repeated?__________

Teachers report problems in:

Reading	attention/concentration
spelling	behavior
arithmetic	social adjustment
writing	

Grade: **Problems Noted?**

_______ ____

_______ ____

_______ ____

________ ____

________ ____

________ ____

Was your child unusually hyperactive? _______ inattentive? _______

Do teachers report problems that you do not notice?_____________

____

My child's intelligence level is likely:

below average

average

high average

superior

His/her mother's intelligence level is likely:

below average

average

high average

superior

His/her father's intelligence level is likely:

below average

average

high average

superior

Prior Psychological History

Have you previously had direct contact with any neurologist, psychologist, psychiatrist, clinic or private agency?______________________________

Date Name of professional

________ ____

________ ____

________ ____

________ ____