PEDIATRIC NEUROPSYCHOLOGY SERVICES, PLLC

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Background Information Form
Reassessment For Prior Patients Only

(Please only complete if your child was assessed by Dr. Lurie in earlier years)

Child's Name:
____

Name of person filling out this questionnaire:
____

Reason you are requesting this reassessment:
____
____
____

Describe some of your child's current strengths:
____
____
____

Describe some of your child's current weaknesses:
____
____
____

Any specific concerns since the prior assessment:
____
____
____
____
____
____

Names and ages of family members living with child:
____
____
____

What medications does the child currently take?
____
____
____

Are there any significant family or marital conflicts? Explain
____
____

Social Behavior

Does your child have friends? _________keep friends? _________________

understand gestures? _________have a good sense of humor? _________

understand social cues well?_________have problems with peer pressure (e.g., alcohol or drug use)? ____

Medical History

Has vision been checked within the last year? ______________________________
Any problems:____

Has hearing been checked within the last year? ______________________________
Any problems:____

CT, MRI, or EEG obtained?_________Date:__________ Results: _____________

Any problems with the child's personal hygiene currently?
____
____

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

List serious illnesses/injuries/hospitalizations/surgeries

Date	Incident (explain)
______	____
______	____
______	____
______	____

Is there a history of:

epilepsy? ____________________
staring spells? ____________________
lead poisoning/toxic ingestion? ____________________
meningitis or encephalitis? ____________________
asthma? ____________________
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?____________________

Is there a family history of learning difficulties?

____
____

Is there a family history of neurological illness?

____
____

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

Previous schools attended and age:
____
____
____
____
____

Current school or college (if applicable):
____

Grade:____

Any grades that were skipped or repeated?__________

Current Placement: regular __ resource __ special education __

History of academic difficulties:

Grade:	Problems Noted?
_______	____
_______	____
_______	____
_______	____
_______	____
_______	____

Prior Psychological History

Has your child previously had direct contact with any neurologist, psychologist, psychiatrist, clinic or private agency?_______________________________

Date	Name of professional
_______	____
_______	____
_______	____

Has your child ever been hospitalized in a psychiatric unit?________________________________

Date	Name of hospital	Diagnosis (if known)
________	__________________________	____________________
________	__________________________	____________________

Prior Educational or Psychiatric Diagnoses:

Age:	**Diagnosis**
________	____
________	____
________	____

Any other areas of concern not noted above:

____
____
____
____
____
____