PEDIATRIC NEUROPSYCHOLOGY SERVICES, PLLC

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BACKGROUND INFORMATION FORM – YOUNG ADULT

PATIENT INFORMATION

Patient's Name:

Date of Birth:

Age:

Person completing this form:

Relationship to patient:

REASON FOR REFERRAL

Reason you are requesting this evaluation:

Who referred you to my practice?

Describe the patient's strengths:

Describe the patient's weaknesses:

FAMILY INFORMATION

Household members living with patient (names, ages, gender):

Parents are ☐ Married ☐ Divorced ☐ Separated ☐ Remarried

Any significant family conflict? Explain:

Is the patient currently in school? Explain:

Is the patient currently employed? Explain:

History of the patient's employment:

PREGNANCY AND BIRTH HISTORY

Birth location (city/state/country):

Mother's age at delivery: _____ Father's age: _____

Any known health problems of mother during pregnancy:

Medications / alcohol / tobacco / drugs during pregnancy:

Delivery type: ☐ Vaginal ☐ Cesarean

Reason for c-section if applicable:

Gestational age: ☐ Full term ☐ Premature (_____ weeks)

Birth weight: _____ lb. _____ oz.

Labor complications:

Birth complications (including positioning, meconium staining, blue skin):

Newborn health concerns:

Oxygen needed ☐ Yes ☐ No

NICU ☐ Yes ☐ No **Length of stay in NICU_____**

Hospital discharge age:

Early infancy (check if applicable):

- Fussy/colicky ☐
- Feeding difficulties ☐
- Sleep problems ☐
- Medical complications ☐

Describe:

DEVELOPMENTAL HISTORY

Motor Development

Milestones:

Sat alone: _____ Crawled: _____Walked: _____

Motor coordination concerns? ☐ Yes ☐ No
Describe:

Handedness: ☐ Right ☐ Left ☐ Mixed

PT or OT services? ☐ Yes ☐ No
Describe reason and ages:

Speech and Language

First words age: _____Two-word phrases age: _____

Speech/language concerns:

Speech therapy received? ☐ Yes ☐ No
Describe reason and ages:

Other languages spoken at home:

Toileting

Age toilet trained: _____

Problems with toileting:

Hygiene concerns:

MEDICATIONS

Current medications (include dose and prescriber information):

MEDICAL HISTORY

Vision checked within last year? ☐ Yes ☐ No
Concerns:

Hearing checked within last year? ☐ Yes ☐ No
Concerns:

Neurological testing (CT/MRI/EEG):
Date(s): _____
Results:

Significant medical history (hospitalizations, injuries, surgeries, concussions):

History of (check if applicable):

- Seizures ☐
- Staring spells ☐
- Head injuries ☐
- Asthma ☐
- Allergies ☐
- Headaches ☐
- Sleep problems ☐
- Tics ☐
- Loss of consciousness ☐

Explain:

FAMILY HISTORY

Learning difficulties in relatives:

Neurological conditions in relatives:

Psychiatric conditions in relatives:

Do any other family members have challenges similar to the patient:

EDUCATIONAL HISTORY

Schools attended (list from preschool and include grades at each school):

Current school or college (if applicable):

Current grade:

Any grade retention or skipping? ☐ Yes ☐ No
Explain:

Academic concerns by grade level:

SOCIAL FUNCTIONING

Has friends? ☐ Yes ☐ No
Keeps friends? ☐ Yes ☐ No

Social skills concerns:

Hobbies/interests/sports/extracurricular activities:

Describe relationships with different family members:

PSYCHOLOGICAL HISTORY

Prior testing? ☐ Yes ☐ No

When and name of provider (please attach prior test reports):

Diagnoses given:

Mental health providers seen, dates, and reason:

Psychiatric hospitalization? ☐ Yes ☐ No

Details:

OTHER CONCERNS