PEDIATRIC NEUROPSYCHOLOGY SERVICES, PLLC

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BACKGROUND INFORMATION FORM – PRIOR PATIENT (CHILD)

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

CHILD INFORMATION

Child's Name:

Date of Birth:

Age:

Person completing this form:

Relationship to child:

REASON FOR REFERRAL

Reason you are requesting this reassessment:

Any specific concerns since the prior assessment:

PARENT / CAREGIVER IMPRESSIONS

In your opinion, the major cause of your child's current difficulties is:

Describe your child's strengths:

Describe your child's weaknesses:

What would your child say are their strengths?

What would your child say are their weaknesses?

FAMILY INFORMATION

Household members (names, ages, relationship, gender):

Parents are ☐ Married ☐ Divorced ☐ Separated ☐ Remarried

Do both parents agree about current concerns?
☐ Yes ☐ No ☐ Unsure
Explain:

Any significant current family or marital conflict?
☐ Yes ☐ No
Explain:

Has the child experienced death or separation from a loved one since the prior testing?
☐ Yes ☐ No
Explain:

If applicable, what are the custody / living arrangements (please also attach custody agreement if I do not already have it):

MEDICAL HISTORY

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

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

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

Significant medical history since prior testing (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, neurological conditions, and/or psychiatric conditions in relatives:

Do any other family members have challenges similar to the child? Explain:

EDUCATIONAL HISTORY

Since the prior testing, what schools and grades were attended:

Current school:

Current grade:

Current placement:
☐ Regular education
☐ Resource programming
☐ Special education

Academic concerns noted since prior testing:

SOCIAL FUNCTIONING

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

Current social skills concerns:

Current hobbies/interests/sports/extracurricular activities:

Describe relationships with different family members:

PSYCHOLOGICAL HISTORY

Any updated testing since the last assessment by Dr. Lurie? ☐ Yes ☐ No

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

Diagnoses given:

Mental health providers seen since prior testing, include dates and reason:

Psychiatric hospitalizations since prior testing? ☐ Yes ☐ No

Details:

OTHER CONCERNS