PEDIATRIC NEUROPSYCHOLOGY

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Child Information Form

Thank you for taking the time to complete this form. The information you provide will be very helpful to your child's doctor.

Today's date: ___________________________

REFERRAL INFORMATION

Child's full name: ______________________________ Sex: ☐ Male ☐ Female Date of birth: ___________

Name of person filling out this form: __________________________ Relationship to child: _______________

Names of parents or legal guardian: ____
Address of parents or legal guardian: ____
____

Phone number of parents or legal guardian: ____

Name of referring physician: ____
Address of referring physician: ____
____

Phone number of referring physician: ____

Why was your child referred for a neuropsychological assessment?

____
____
____
____

Are there any specific questions you are hoping to have answered by this assessment?

____
____
____
____

What did you tell your child about coming to the appointment?

____
____
____
____

FAMILY INFORMATION

Child is: ☐ Biological/Natural ☐ Adopted ☐ Foster-child ☐ Step-child

Highest grade completed by biological mother: _______ Highest grade completed by biological father: ______
Biological Mother's occupation: ____________________ Biological Father's occupation: ____________________

Parent's marital status: ☐ Married ☐ Divorced ☐ Separated ☐ Never married ☐ Remarried ☐ Deceased
If separated or divorced, age of child at the time: ______________

Living arrangement: ☐ with both parents ☐ with one parent ☐ alternates between parents
Lives with a different family (not parents): ____

Are there any significant family or marital conflicts? ☐ No ☐ Yes (explain):

____

____

Please list all adults and children living in the home with your child:

Name	Age	Relationship to Child

PREGNANCY AND BIRTH

Were there any problems or complications during the pregnancy? ___ No ____ Yes (explain):

____

____

____

Length of pregnancy (weeks) ________ Number of weeks early ________ or late ________

Type of delivery: ☐ Vaginal ☐ Breech ☐ Cesarean ☐ Forceps Aided

Were there any complications during the delivery? ___ No ____ Yes (explain):

____

____

____

Birth weight: ________ lbs. ________ oz. Number of days in the hospital: ________

Apgar scores, if known: ________ / ________ Was oxygen needed to help with breathing? Yes/No

Newborn difficulties: ☐ None ☐ Cyanosis (turned blue) ☐ Stay in NICU or special care nursery
Other: ____

____

____

DEVELOPMENTAL

Indicate the age at which your child achieved the following:

Sat without support	_________	Spoke first words	_________
Crawled	_________	Put 2-3 words together	_________
Walked	_________	Spoke in sentences	_________
Toilet Trained	_________		

Motor Abilities

Does your child have problems with motors skills (running, skipping, climbing, biking, playing ball, fastening clothes, using eating utensils)? ___ No ___ Yes

Has your child ever received occupational therapy? ___ No ___ Yes (age(s): _________________)

Has your child ever received physical therapy? ___ No ___ Yes (age(s): _________________)

Child's Handedness: ___ right ___ left ___ both/ambidextrous

Is there a family history of left handedness? ___ No ___ Yes (list relatives)

Name	Relationship to Child
______________________________	______________________
______________________________	______________________
______________________________	______________________

Speech/Language

Does your child have any speech/language problems (stutters, difficult to understand, trouble finding words when speaking, difficulty understanding conversation)? ___ No ___ Yes

Has your child ever received speech/language therapy? ___ No ___ Yes (age(s): _________________)

Language(s) spoken at home (besides English): ______________________________________

What is your child's preferred language ___ English ___ Spanish ___ Other: _________________

Toileting

Any current problems with bedwetting, urine accidents, soiling? ___ No ___ Yes

MEDICAL

Has vision been checked within the past year? ___ No ___ Yes

Describe any vision problems: ____

Eyeglasses for reading or close work – farsighted? ___ No ___ Yes

Eyeglasses for distance – nearsighted? ___ No ___ Yes

Eye surgeries? ___ No ___ Yes

Has hearing been checked within the past year? ___ No ___ Yes

Describe any hearing problems: ____

Hearing aids? ___ No ___ Yes

Ear tubes? ___ No ___ Yes

List serious illnesses/injuries/hospitalizations/surgeries not related to your child's current illness.

Date	Incident (Explain)
____________	____
____________	____
____________	____
____________	____

Check any current or prior problem(s)		Age(s)	Comments
	Seizures or Epilepsy		
	Staring Spells		
	Loss of Consciousness		
	Concussion, head or brain injury		
	Headaches		
	Brain Tumor		
	Brain Infection		
	Meningitis or Encephalitis		
	Hydrocephalus		
	Heart or Blood Disorder		
	Stomach or Digestive Disorder		
	Muscle Disorder		
	Skeletal/Bones Abnormality		
	Lung or Breathing Disorder		
	Genetic/Chromosomal Disorder		
	Skin Condition		
	Cancer		
	Head/Skull/Face Abnormality		
	Endocrine Disorder		
	Pain		
	Appetite, Weight Concerns		
	Sleep Disorder		
	Tobacco, Recreational Drugs, Alcohol Use		

Please add any additional information about the above concerns:

____
____
____
____

Has your child ever had a mental health evaluation or received treatment by a psychologist, psychiatrist, counselor, or social worker? ___ No ___ Yes (explain):

Name of professional:	Dates:	Reason for the evaluation and/or treatment:

Current Medication(s):	Reason(s) for the medication(s):

EDUCATIONAL

Current School: ______________________________ Grade: __________

Are you satisfied with your child's school program? ___ No ___ Yes

Teachers report problems in: (check all that apply)

___ Reading ___ Spelling ___ Writing ___ Math ___ Language

___ Homework ___ Work Habits ___ Organization ___ Motor Skills ___ Attention/Concentration

___ Emotions ___ Behavior ___ Social Skills ___ Other: ______________________

Check any special services your child has or currently receives:

___ Individualized Educational Plan (IEP) ___ 504 Plan ___ Resource Room ___ Special Education

___ Tutoring ___ Title I Services ___ Other special services: ______________________

Has your child ever repeated a grade? ___ No ___ Yes

Has your child ever had special testing at school? ___ No ___ Yes (date(s): ______________)

SOCIAL

Do you have concerns about your child's social skills or ability to get along with others? ___ No ___ Yes

Is your child involved in any clubs, organizations, or sports teams? ___ No ___ Yes

What are your child's favorite activities during free time? ______________________

____

Describe some of your child's strengths: ______________________

____

Describe some of your child's weaknesses: ______________________

____

Check problems experienced by your child		Comments
	Parent relationship/marital problems	
	Separation from a loved one/friend	
	Death of a family member/friend/pet	
	Illness or injury of a family member/friend	
	Financial problem of parent/job loss	
	Legal problem of parent or family member	
	Experiencing a traumatic event	
	Physical or sexual abuse	
	Neglect	
	Involvement by Child Protective Services (CPS)	

Other stressors: ____

____

Please rate the overall degree of your family's stress *in the past year*:

☐ Very High Stress ☐ Higher than Typical ☐ Typical Stress ☐ Lower than Typical ☐ Very Little Stress

Please rate your child's overall quality of life over the *past 6 months*:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

If needed, please feel free to provide additional comments about your child on the back of this form.