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**Background Questionnaire**

**(Confidential: For Report Purposes Only)**

*Thank you for filling out this questionnaire. Know that this information is very important to the assessment, so please be comprehensive and provide as much detail as possible. At the end of each section is an area for you to add any additional notes.*

Today’s Date: Click here to enter a date.

Form completed by: Click here to enter your name. Your relationship to child: Choose an item.

Additional Notes: Click here to enter text.

**1. CONTACT AND DEMOGRAPHIC INFORMATION**

Child’s name: Click here to enter text. Birthdate: Click here to enter text. Age: Click here to enter text.

Grade: Click here to enter text. Sex: Choose an item.

Home address: Click here to enter text.

Best Email: Click here to enter text. Best Phone: Click here to enter text. Type: Choose an item.

1) Parent’s name: Click here to enter text. Relationship to child: Choose an item. Age: Click here to enter text.

Highest grade completed / Degree(s): Click here to enter text. Occupation: Click here to enter text. Work: Choose an item.

Phone: Home Click here to enter text. Work Click here to enter text. Cell Click here to enter text.

2) Parent’s name: Click here to enter text. Relationship to child: Choose an item. Age: Click here to enter text.

Highest grade completed / Degree(s): Click here to enter text. Occupation: Click here to enter text. Work: Choose an item.

Phone: Home Click here to enter text. Work Click here to enter text. Cell Click here to enter text.

3) Parent’s name: Click here to enter text. Relationship to child: Choose an item. Age: Click here to enter text.

Highest grade completed / Degree(s): Click here to enter text. Occupation: Click here to enter text. Work: Choose an item.

Phone: Home Click here to enter text. Work Click here to enter text. Cell Click here to enter text.

List all people living / working in household (including parents, children, and housekeepers/nannies). *Please include name, age, and relationship to child for each person listed.* Click here to enter text.

If any parents, brothers or sisters are living outside the home, list their names and ages: Click here to enter text.

Primary language spoken in the home: Click here to enter text.

Other languages spoken in the home: Click here to enter text. By whom: Click here to enter text.

Ethnicity / Race: Click here to enter text. Religion: Click here to enter text.

Additional Notes: Click here to enter text.

**2. PRESENTING SITUATION**

Who referred you for an evaluation? Click here to enter text.

What is this person’s professional role or relationship to you? Click here to enter text.

Why did this person refer you for an evaluation? Click here to enter text.

What are your primary concerns about your child? Click here to enter text.

When were these difficulties first noticed by you? Click here to enter text.

What information would you like this assessment to provide? What questions do you hope to have answered by this evaluation? Click here to enter text.

Please describe your child’s strengths. (Academically, socially, behaviorally, hobbies, etc.) Click here to enter text.

What are your child’s favorite activities? Click here to enter text.

What activities would your child like to engage in more than he/she does at present? Click here to enter text.

What activities does your child like the least? Click here to enter text.

Additional Notes: Click here to enter text.

**3. SOCIAL AND BEHAVIORAL CHECKLIST**

*Click the right hand column next to any behavior or problem that your child currently exhibits. For any item that your child has exhibited in the past but is no longer a problem, please click the left column.*

**Prior Current Prior Current**

Poor conversational skills

Needs repetition

Cannot follow commands with more than two steps

Difficulty understanding words

Difficulty understanding sentences

Seems to misunderstand others

Has difficulty producing speech

Speaks in monotone (very little emotion in speech)

Has difficulty with articulation

Constantly substitutes one sound for another

Describe: Click here to enter text.

Has difficulty organizing sounds

Repeats sounds or syllables

Interjects sounds or words into speech

Prolongs words or sounds

Has broken words (e.g. pauses within a word)

Difficulty finding words

Limited vocabulary

Uses vague language (that, thing, etc.)

Makes errors in word structure, such as tense, plurals, pronouns, etc.

Difficulty organizing phrases and sentences

Abandons phrases and sentences

“Re-works” phrases and sentences

Difficulty producing (complex) sentences

Has difficulty expressing self with language

Has difficulty with hearing

Has difficulty with vision

Often has to be touching or leaning against something

Dislikes riding in cars / Easily carsick

Avoids / Dislikes playground equipment

Dislikes rides at amusement parks (e.g. roller coasters, spinning, etc.)

**Overly sensitive or under-responsive to any of the following:**

*For each one checked, please indicate if over (o) or under (u) sensitive and provide examples*.

Touch o u Click here to enter examples.

Tactile texture (e.g. clothing, blankets)

o u Click here to enter examples.

Having hair brushed o u

Brushing teeth o u

Additional Notes: Click here to enter text.

Taking a bath / shower o u

Temperature o u Click here to enter examples.

Movement o u Click here to enter examples.

Pain o u Click here to enter examples.

Light o u Click here to enter examples.

Noise o u Click here to enter examples.

Smell o u Click here to enter examples.

Taste/texture o u Click here to enter examples.

Eats poorly

Eating habits are poor or unusual

Has difficulty with fine coordination (e.g. picking up small items, etc.)

Has difficulty with gross motor coordination

Has difficulty with balance

Motor / Vocal tics Explain: Click here to enter text.

Oral (mouth) motor problems

Wets bed How often: Click here to enter text.

Has poor bowel control (soils self)

If yes, how often? Click here to enter text.

Only at night? Click here to enter text.

Is clumsy (bumps, near-trips, etc.)

Drops things

Poor handwriting

Poor performance in sports

Not well coordinated in walking or moving

Accidentally falls off chairs or other furniture

Does things slower than other children

Prefers to be alone

Prefers to play alone

Does not get along well with brothers and sisters

Lack of make-believe play

Excessive make-believe play

Lack of age appropriate peer relationships

Imitates peers, or moves alongside peers, without actually “joining” in interactive play

Does not show much affection

Does not appear to form an emotional bond or connection with others

More interested in things (objects) than in people

Preoccupied with parts of objects

Shows no particular or special interest in people

Does not share interests or excitement with others

Poor eye contact

Lack of facial expression

Lack of interpersonal reciprocity (give and take in conversation)

Addit

Additional Notes: Click here to enter text.

**Prior Current**

Lack of social reciprocity (give and take in groups)

Lack of emotional reciprocity (give and take in affect and emotion)

Lack of social gestures (acknowledging, waving, smiling, etc.)

Odd movements (posturing, peculiar hand movements, etc.)

Hand flapping

Hand wringing

Idiosyncratic language

Poor or unusual body postures

Self mutilates

Self-stimulates at home

Self-stimulates in public places

Rocks back and forth

Repetitive verbal or motor behaviors

Holds breath

Bangs head

A “different” child

Does not like change in routines

Makes comments that are completely unrelated to context

Has frequent tantrums or temper outbursts

How often? Click here to enter text.

How long do they last on average? Click here to enter text.

What triggers it? Click here to enter text.

Has frequent nightmares

Has night terrors

Mood changes quickly and drastically

Feels sad

Cries a lot

Irritable

Not interested in most activities

Not gaining expected weight

Lacks energy

Seems tired all the time

Indecisive

Has some type of disturbance with sleep:

Can’t fall asleep

Stays up too late

Wakes up during the night

Wakes up too early

Sleepwalking

Nightmares

Other: Click here to enter text.

Additional Notes: Click here to enter text.

**Prior Current**

Seems unable to concentrate due to sad mood

Expresses feelings of worthlessness

Expresses thoughts about death

Expresses thoughts about hurting self

Is shy or timid

Has worries

Has fears (describe): Click here to enter text.

Has habits or mannerisms that appear anxious (describe): Click here to enter text.

Bites nails

Sucks thumb

Low frustration threshold

Often touchy or easily annoyed by others

Clingy with parents or caretakers

Has blank spells, stares off

Is slow to learn

Gives up easily with challenge

Daydreams

Poor attention span

Often loses things, then asks where things are

Doesn’t seem to listen

Doesn’t learn from experience

Poor memory / Forgets things

Messy or Disorganized

Engages in behavior that could be dangerous to self or others (describe): Click here to enter text.

Is much too active, hyperactivity

Acts like he or she is driven by a motor

Wears out shoes more frequently than other siblings

Heedless to danger

Often engages in physically dangerous activities, shows daredevil behavior

Difficulty playing quietly

More active than siblings

Is impulsive in behavior, reacts too quickly

Acts before thinking

Poor self-control

Is impulsive in talking, interrupts frequently

Often talks excessively

Sloppy table manners

Seems immature for age

Social skills are poor

Blames others for own mistakes

Is often angry or resentful

Often argues with adults

Stealing

Lying

Additional Notes: Click here to enter text.

**Prior Current**

Sudden outbursts, verbal or physical abuse of other children

Is stubborn

Is aggressive

Has negativistic and independent behavior

Erroneous / false beliefs

Unusual interpretations / perceptions of experiences Describe: Click here to enter text.

Has sensory experiences that are not real Describe: Click here to enter text.

Hearing something that is not there (e.g. voices) Describe: Click here to enter text.

Seeing something that is not there Describe: Click here to enter text.

Other: Click here to enter text.

Additional Notes: Click here to enter text.

How would you rate your child’s overall level of intelligence compared to other children the same age?

Below Average  Average  Above Average

How would you rate your child’s overall level of academic performance compared to other children the same age?

Below Average  Average  Above Average

How would you rate your child’s level/degree of behavior problems compared to other children the same age?

Less than Average  Average  More than Average

How would you rate your child’s overall social skills compared to other children the same age?

Below Average  Average  Above Average

How would you rate your child’s overall level of emotional/psychological adjustment compared to other children the same age?  Below Average  Average  Above Average

Additional Notes: Click here to enter text.

**4. EDUCATION AND SCHOOL HISTORY**

Present School: Click here to enter text. School District: Click here to enter text. Type of School: Choose an item.

School Address: Click here to enter text.

My child likes school:  All or most of the time  Sometimes  Almost never

My child’s current grades are (choose the appropriate system):  ungraded class

A&B  B&C  C&D  D&F

Outstanding  Good  Satisfactory  Improvement Needed  Unsatisfactory

90’s 80’s  70’s  60’s  Below 60

Compared to previous years, my child’s grades have:  Stayed the same  Improved  Declined

Do teachers report any of the following behaviors at school?

Doesn’t respect authority  Social or peer difficulties  Anger or aggressiveness

Atypical or unusual behaviors  Easily distracted  Shouts out

Doesn’t sit still in his/her seat  Doesn’t want to be called on  Won’t wait his/her turn

Difficulty following instructions  Difficulty sustaining attention  Is teased / bullied

Meanness or teasing other  Shifts from one activity to another Doesn’t respect the rights of others

Doesn’t pay attention during storytelling or show and tell  Typically does better in a one to one relationship

Frequently gets up and walks around the classroom  Doesn’t cooperate well in group activities

To what degree do the following impact your child’s performance and/or engagement in school:

Structured vs. Unstructured Classroom: Click here to enter text.

Structured vs. Unstructured Teacher: Click here to enter text.

Class size: Click here to enter text.

Relationship to teacher: Click here to enter text.

Interest in the subject: Click here to enter text.

Your child’s best subject(s): Click here to enter text. Your child’s hardest subject(s): Click here to enter text.

My child currently exhibits the following academic problem(s):  Difficulty with reading  Difficulty with arithmetic

Difficulty with spelling  Difficulty with writing  Difficulty with other subjects: Click here to enter text.

Describe your child’s favorite, disliked, and difficult subjects in the past: Click here to enter text.

Additional Notes: Click here to enter text.

**School History**

Age began school: Click here to enter text.

**Names of Schools**

Preschool: Click here to enter text. Hours per day / Days per week: Click here to enter text.

Preschool: Click here to enter text. Hours per day / Days per week: Click here to enter text.

School: Click here to enter text. Grade level: Click here to enter text.

School: Click here to enter text. Grade level: Click here to enter text.

School: Click here to enter text. Grade level: Click here to enter text.

Has your child ever had an IEP? (Please be sure to provide copies of these records.)  Yes  No

If yes, when was the initial meeting? (Approximate date okay) Click here to enter text.

When were the following IEPs? Click here to enter text.  
My child has been in the following classes:

Resource room  LD class (full time)  Emotional/Behavior problems

Advanced Instruction  LD class (part time)  Other:

Has your child ever repeated or skipped a grade?  Yes  No

If yes, please explain: Click here to enter text.

Has your child ever been expelled from school?  Yes No

Has a school ever threatened to expel your child, or was your child asked to leave or change schools because of behavior?  Yes  No

In school, my child:

Gets along well with other children / has friends OR  Does not get along with other children

Gets along well with the teacher(s) OR  Does not get along with the teacher(s)

Additional Notes: Click here to enter text.

**5. EVALUATIONS AND SERVICES**

**Previous Evaluations**

*Check any tests or evaluations that have been conducted with your child.*

**Date: (approx. o.k.) Results (your best recall is fine):**

Occupational therapy evaluation Click here to enter date. Click here to enter results.

Physical therapy evaluation Click here to enter date. Click here to enter results.

Psychiatric evaluation Click here to enter date. Click here to enter results.

Psychological evaluation Click here to enter date. Click here to enter results.

Neuropsychological evaluation Click here to enter date. Click here to enter results.

School testing Click here to enter date. Click here to enter results.

Speech / Language testing Click here to enter date. Click here to enter results.

Vision testing Click here to enter date. Click here to enter results.

Other: Click here to enter text. Click here to enter date. Click here to enter results.

**Services**

Please provide copies of your most recent Individual Education Plan (IEP), Regional Center assessment or Individual Family Service Plan (IFSP), and any other relevant reports. In addition, please provide copies of any records, progress notes, or reports from any of the services listed below.

*Check the interventions currently or previously received. For each intervention, please provide the details requested. If clinic based, and more than one person provided treatment, please provide the name of the “lead” person.*

Speech Therapy (articulation) Age range/Grade level of treatment: Click here to enter text.

Minutes or # of sessions per week: Click here to enter text.  Individual or  Group

Name/Agency/Setting of Provider: Click here to enter text. Provider’s credentials: Click here to enter text.

Language Therapy Age range/Grade level of treatment: Click here to enter text.

Minutes or # of sessions per week: Click here to enter text.  Individual or  Group

Name/Agency/Setting of Provider: Click here to enter text. Provider’s credentials: Click here to enter text.

Occupational Therapy Age range/Grade level of treatment: Click here to enter text.

Minutes or # of sessions per week: Click here to enter text.  Individual or  Group

Name/Agency/Setting of Provider: Click here to enter text. Provider’s credentials: Click here to enter text.

Physical Therapy Age range/Grade level of treatment: Click here to enter text.

Minutes or # of sessions per week: Click here to enter text.  Individual or  Group

Name/Agency/Setting of Provider: Click here to enter text. Provider’s credentials: Click here to enter text.

Adaptive P.E. Age range/Grade level of treatment: Click here to enter text.

Minutes or # of sessions per week: Click here to enter text.  Individual or  Group

Name/Agency/Setting of Provider: Click here to enter text. Provider’s credentials: Click here to enter text.

Educational Therapy Age range/Grade level of treatment: Click here to enter text.

Minutes or # of sessions per week: Click here to enter text.  Individual or  Group

Name/Agency/Setting of Provider: Click here to enter text. Provider’s credentials: Click here to enter text.

Tutoring Age range/Grade level of treatment: Click here to enter text.

Minutes or # of sessions per week: Click here to enter text.  Individual or  Group

Name/Agency/Setting of Provider: Click here to enter text. Provider’s credentials: Click here to enter text.

Educational Service (School District) Age range/Grade level of treatment: Click here to enter text.

Minutes or # of sessions per week: Click here to enter text.  Individual or  Group

Name/Agency/Setting of Provider: Click here to enter text. Provider’s credentials: Click here to enter text.

Educational Service (Private) Age range/Grade level of treatment: Click here to enter text.

Minutes or # of sessions per week: Click here to enter text.  Individual or  Group

Name/Agency/Setting of Provider: Click here to enter text. Provider’s credentials: Click here to enter text.

Social Skills Training Age range/Grade level of treatment: Click here to enter text.

Minutes or # of sessions per week: Click here to enter text.  Individual or  Group

Name/Agency/Setting of Provider: Click here to enter text. Provider’s credentials: Click here to enter text.

Psychotherapy Age range/Grade level of treatment: Click here to enter text.

Minutes or # of sessions per week: Click here to enter text.  Individual or  Group

Name/Agency/Setting of Provider: Click here to enter text. Provider’s credentials: Click here to enter text.

Assistive Technology Age range/Grade level of treatment: Click here to enter text.

Minutes or # of sessions per week: Click here to enter text.  Individual or  Group

Name/Agency/Setting of Provider: Click here to enter text. Provider’s credentials: Click here to enter text.

Classroom Accommodations Age range/Grade level of treatment: Click here to enter text.

Minutes or # of sessions per week: Click here to enter text.  Individual or  Group

Name/Agency/Setting of Provider: Click here to enter text. Provider’s credentials: Click here to enter text.

Other: Click here to enter text. Age range/Grade level of treatment: Click here to enter text.

Minutes or # of sessions per week: Click here to enter text.  Individual or  Group

Name/Agency/Setting of Provider: Click here to enter text. Provider’s credentials: Click here to enter text.

Additional Notes: Click here to enter text.

**6. DEVELOPMENTAL HISTORY**

*If adopted, please answer the following questions to the best of your knowledge.*

If child was adopted, please indicate at what age: Click here to enter text.

During pregnancy, was the mother on any prescription medication?  Yes  No

If yes, what kind, for what problem, during what month, and for how long? Click here to enter text.

During pregnancy, did the mother smoke?  Yes  No

If yes, how many cigarettes each day? Click here to enter text.

During pregnancy, did the mother drink alcoholic beverages?  Yes  No

If yes, what did the mother drink? Click here to enter text.

Approximately how much alcohol was consumed each day / week? Click here to enter text.

During pregnancy, did the mother use drugs?  Yes  No

If yes, what kind? Click here to enter text.

Were there any complications during pregnancy (excessive vomiting, excessive staining/blood loss, threatened miscarriage, infections(s), toxemia, etc.)?  Yes  No

If yes, please explain: Click here to enter text.

Duration of pregnancy (weeks): Click here to enter text. Duration of labor (hours): Click here to enter text.

APGARs Click here to enter text. Additional APGARs Click here to enter text.

Birth Weight: Click here to enter text.

What was your first impression of your baby? Click here to enter text.

*Click any of the following that apply. For items clicked, please include the details requested.*

There were indications of fetal distress during labor or during birth. Describe: Click here to enter text.

Forceps were used during delivery. For what reason? Click here to enter text.

A Cesarean section was performed. For what reason? Click here to enter text.

Delivery was induced? For what reason? Click here to enter text.

Delivery was spontaneous normal vaginal delivery (SNVD).

Child was premature. By how many months? Click here to enter text.

There were birth defects or complications. Please describe: Click here to enter text.

There was depression during the immediate post-natal period. Please describe: Click here to enter text.

Child was breastfed. For how long? Click here to enter text.

There were feeding problems. Please describe: Click here to enter text.

There were sleeping problems. Please describe: Click here to enter text.

*Click any of the following that apply.*

As an infant, my child was quiet.

As an infant, my child was alert.

As an infant, my child liked to be held.

As an infant, my child maintained eye gaze.

As an infant, my child attended to noises in the environment.

As an infant, my child visually tracked objects.

As an infant, my child appeared “under-responsive” (tired, slow to react, etc.).

*Click any of the following present (to a significant degree) during the first few years of life:*

Did not enjoy cuddling. Please describe: Click here to enter text.

Did not make eye contact. Please describe: Click here to enter text.

Did not anticipate / “mold” to being picked up. Please describe: Click here to enter text.

Arched back. Please describe: Click here to enter text.

Recoiled from touch. Please describe: Click here to enter text.

Was not calmed by being held or stroked. Please describe: Click here to enter text.

Colic. Please describe and indicate for how long: Click here to enter text.

Excessive restlessness. Please describe: Click here to enter text.

Prolonged diminished sleep. Please describe: Click here to enter text.

Head banging. Please describe: Click here to enter text.

Constantly into everything. Please describe: Click here to enter text.

Excessive number of accidents compared to other children. Please describe: Click here to enter text.

Cried a lot. Please describe: Click here to enter text.

Were there any special problems in the growth and development of your child during the first few years?  Yes  No

If yes, please describe: Click here to enter text.

**Infant and Preschool Behaviors**

*Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, type the age followed by a question mark. If you don’t remember the age at which the behavior occurred, please type a question mark.*

Showed response to mother: Click here to enter age.

Smiled: Click here to enter age.

Rolled over: Click here to enter age.

Sat Alone: Click here to enter age.

Crawled: Click here to enter age.

Walked without assistance: Click here to enter age.

Babbled: Click here to enter age.

Spoke first word: Click here to enter age.

Spoke single words (other than “mama” or “dada”): Click here to enter age.

Vocabulary burst: Click here to enter age.

Said phrases: Click here to enter age.

Said sentences: Click here to enter age.

Dressed self (donning shirts/pants): Click here to enter age.

Buttoned clothing: Click here to enter age.

Managed all fasteners: Click here to enter age.

Donned socks and shoes: Click here to enter age.

Tied shoelaces: Click here to enter age.

Began to use utensils: Click here to enter age.

Mastered utensils: Click here to enter age.

Bladder trained, day: Click here to enter age.

Bladder trained, night: Click here to enter age.

Stayed dry at night: Click here to enter age.

Bowel trained: Click here to enter age.

Rode tricycle: Click here to enter age.

Rode bicycle (without training wheels): Click here to enter age.

Named colors: Click here to enter age.

Named shapes: Click here to enter age.

Named coins: Click here to enter age.

Said alphabet in order: Click here to enter age.

Identified all letters accurately: Click here to enter age.

Began to read: Click here to enter age.

*Rate your child on the following skills:*

Walking  Excellent  Good  Average  Poor  Can’t do it

Running  Excellent  Good  Average  Poor  Can’t do it

Throwing  Excellent  Good  Average  Poor  Can’t do it

Catching  Excellent  Good  Average  Poor  Can’t do it

Overall athletic abilities  Excellent  Good  Average  Poor  Can’t do it

Shoelace tying  Excellent  Good  Average  Poor  Can’t do it

Cutting  Excellent  Good  Average  Poor  Can’t do it

Manipulating small objects  Excellent  Good  Average  Poor  Can’t do it

Writing (graphomotor)  Excellent  Good  Average  Poor  Can’t do it

Additional Notes: Click here to enter text.

**7. MEDICAL HISTORY**

Date of last physical examination: Click here to enter text.

Date of last vision examination: Click here to enter text.

Date of last hearing examination: Click here to enter text.

*Click any illness or condition that your child has or has had. For each item clicked, also note approximate date (or age) of the illness.*

Measles: Click here to enter date(s)/age(s).

German measles: Click here to enter date(s)/age(s).

Mumps: Click here to enter date(s)/age(s).

Chicken pox: Click here to enter date(s)/age(s).

Whooping cough: Click here to enter date(s)/age(s).

Diphtheria: Click here to enter date(s)/age(s).

Scarlet Fever: Click here to enter date(s)/age(s).

Meningitis: Click here to enter date(s)/age(s).

Pneumonia: Click here to enter date(s)/age(s).

Encephalitis: Click here to enter date(s)/age(s).

High Fever: Click here to enter date(s)/age(s).

Injuries to Head: Click here to enter date(s)/age(s).

Broken bones: Click here to enter date(s)/age(s).

Hospitalizations: Click here to enter date(s)/age(s).

Operations: Click here to enter date(s)/age(s).

Dizziness: Click here to enter date(s)/age(s).

Frequent or severe headaches: Click here to enter date(s)/age(s).

Difficulty concentrating: Click here to enter date(s)/age(s).

Memory problems: Click here to enter date(s)/age(s).

Extreme tiredness or weakness: Click here to enter date(s)/age(s).

Rheumatic fever: Click here to enter date(s)/age(s).

Epilepsy: Click here to enter date(s)/age(s).

Tuberculosis: Click here to enter date(s)/age(s).

Bone or joint disease: Click here to enter date(s)/age(s).

Gonorrhea or syphilis: Click here to enter date(s)/age(s).

Anemia: Click here to enter date(s)/age(s).

Jaundice / Hepatitis: Click here to enter date(s)/age(s).

Diabetes: Click here to enter date(s)/age(s).

Cancer: Click here to enter date(s)/age(s).

High blood pressure: Click here to enter date(s)/age(s).

Heart disease: Click here to enter date(s)/age(s).

Ear problems (disease, infection, injury, or impaired hearing): Click here to enter date(s)/age(s).

Otitis media: Click here to enter date(s)/age(s).

Visual problems: Click here to enter date(s)/age(s).

What type? Click here to enter text.

Fainting spells : Click here to enter date(s)/age(s).

Loss of consciousness: Click here to enter date(s)/age(s).

Due to what? Click here to enter text.

Paralysis: Click here to enter date(s)/age(s).

Lead poisoning Click here to enter date(s)/age(s).

Exposure to toxin: Click here to enter date(s)/age(s).

Stomach pumped: Click here to enter date(s)/age(s).

Asthma: Click here to enter date(s)/age(s).

Bleeding problems: Click here to enter date(s)/age(s).

Eczema or hives: Click here to enter date(s)/age(s).

Suicide attempt: Click here to enter date(s)/age(s).

Suspicion of alcohol use: Click here to enter date(s)/age(s).

Suspicion of drug use: Click here to enter date(s)/age(s).

History of physical abuse: Click here to enter date(s)/age(s).

History of sexual abuse: Click here to enter date(s)/age(s).

**Medical Specialists:**

*Click medical specialists your child has or has had. For each item clicked, please provide dates of evaluations and diagnoses given.*

Developmental Pediatrician: Click here to enter text.

Neurology: Click here to enter text.

Suspected seizures  Yes  No If yes, describe: Click here to enter text.

Seizures diagnosed  Yes  No If yes, what type: Click here to enter text.

Genetics: Click here to enter text.

Psychiatry: Click here to enter text.

Gastroenterology: Click here to enter text.

Stomach/intestinal problems  Yes  No If yes, what type: Click here to enter text.

Endocrine: Click here to enter text.

Allergy problems  Yes  No If yes, what type: Click here to enter text.

Other (please specify): Click here to enter text.

*Click the tests or evaluations that have been done in relation to the problem.*

**Date (approximate is okay) Results (impressions are fine):**

Blood Work Click here to enter date. Click here to enter results.

CT Scan Click here to enter date. Click here to enter results.

EEG Click here to enter date. Click here to enter results.

Genetic Testing Click here to enter date. Click here to enter results.

Hearing Testing Click here to enter date. Click here to enter results.

MRI or PET Click here to enter date. Click here to enter results.

Neurologist’s Exam Click here to enter date. Click here to enter results.

Other: Please specify. Click here to enter date. Click here to enter results.

**Medication History**

**Current Medications**

*Please include name of medications, dosage, and frequency.*

1. Click here to enter text. 4. Click here to enter text.

2. Click here to enter text. 5. Click here to enter text.

3. Click here to enter text. 6. Click here to enter text.

Prescribed by: Click here to enter text. Last visit:

Pediatrician: Click here to enter text. Last visit: Click here to enter date.

Neurologist: Click here to enter text. Last visit: Click here to enter date.

Psychiatrist: Click here to enter text. Last visit: Click here to enter date.

Other: Click here to enter text. Last visit: Click here to enter date.

Current medication concerns: Click here to enter text.

**Past Medications**

*Please include name of medications, when taken, and why stopped.*

1. Click here to enter text. 4. Click here to enter text.

2. Click here to enter text. 5. Click here to enter text.

3. Click here to enter text. 6. Click here to enter text.

Additional Notes: Click here to enter text.

**8. FAMILY MEDICAL HISTORY**

*Click any illness or condition that any member of the immediate family (i.e. brothers, sisters, aunts, uncles, cousins, grandparents) has had. For each item clicked, please note the member’s relationship to the child.*

Problems with  aggressiveness,  defiance, and/or  oppositional behavior as a child: Click here to enter relationship to child.

Problems with  attention,  activity, and/or  impulse control as a child: Click here to enter relationship to child.

Behavior problems: Click here to enter relationship to child.

Please explain: Click here to enter text.

Learning disabilities: Click here to enter relationship to child.

Trouble in school with academics (e.g. slow to learn, didn’t like school, underachiever): Click here to enter relationship to child.

Mental retardation: Click here to enter relationship to child.

Psychosis or Schizophrenia: Click here to enter relationship to child.

Depression: Click here to enter relationship to child.

Anxiety disorder that impaired adjustment: Click here to enter relationship to child.

Emotional problems: Click here to enter relationship to child.

Please explain: Click here to enter text.

Tics or Tourette’s: Click here to enter relationship to child.

Alcohol abuse: Click here to enter relationship to child.

Drug abuse: Click here to enter relationship to child.

Suicide attempt: Click here to enter relationship to child.

Antisocial behavior (e.g. assaults, thefts, legal problems): Click here to enter relationship to child.

Physical abuse: Click here to enter relationship to child.

Sexual abuse: Click here to enter relationship to child.

Mental / Verbal abuse: Click here to enter relationship to child.

Cancer: Click here to enter relationship to child.

Diabetes: Click here to enter relationship to child.

Heart trouble: Click here to enter relationship to child.

Neurological condition(s): Click here to enter relationship to child.

Please describe any stressors that I should know of (illness, deaths, operations, accidents, separations, divorce of parents, parent changed job, changed schools, family moved, family financial problems, remarriage, sexual trauma, other losses, other stressor information): Click here to enter text.

Additional Notes: Click here to enter text.

**9. BEHAVIOR AND DISCIPLINE**

How often does your child behave inappropriately? Click here to enter text.

Does your child’s behavior disrupt family activities, events, and outings?  Yes  No If yes, please explain: Click here to enter text.

What disciplinary techniques do you usually use when your child behaves inappropriately? *Click each technique that you usually use.*

Ignore problem behavior  Tell child to sit on chair  Threaten child

Scold child  Send child to his/her room  Reason with child

Take away some activity or food  Spank child  Redirect child’s interest

Don’t use any techniques  Other technique: Click here to enter text.

On the average, what percentage of the time does your child comply with initial commands? Click here to enter text.

On the average, what percentage of the time does your child eventually comply with commands? Click here to enter text.

Who typically disciplines your child? Click here to enter text.

Does your child respond differently based upon who is giving the discipline? Please describe. Click here to enter text.

To what extent are you and other caretakers consistent with respect to disciplinary strategies? Click here to enter text.

Which disciplinary techniques are usually most effective? Click here to enter text.

What disciplinary techniques are usually ineffective? Click here to enter text.

In general, what have you found to be the most satisfactory ways of helping your child? Click here to enter text.

Has your child ever been in trouble with drugs?  Yes  No

Has your child ever been in trouble with the law?  Yes  No

If yes, please describe briefly: Click here to enter text.

Additional Notes: Click here to enter text.

**10. OTHER INFORMATION**

Is there any other information that you think may help me in assessing your child? Click here to enter text.

Is there anything else you would like me to know? Click here to enter text.

Additional Notes: Click here to enter text.