

NEUROPSYCHOLOGY ASSOCIATES, P.C.

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CHILDREN'S HISTORY FORM

INSTRUCTIONS TO PARENTS: Please complete this form and return it to us before your child's appointment. Fill out the form to the best of your knowledge. If some questions are not applicable to your child, write NA. If you need more space or wish to make any additional comments, please attach a separate sheet.

Name of person filling out this form: _____

Relationship to child: _____

Date: _____

Child's Name: _____ Birth date: _____

Referred by: _____ Phone: _____

Reason for Consultation (What are the main questions you would like answered?)

Pediatrician: _____ Phone: _____

If you would like a copy of the report to go to your child's pediatrician, please list the doctor's address here.

Current School: _____ Grade: _____

FAMILY HISTORY

(List parents first, then children in birth order)

	NAME	check if living in the home	AGE	OCCUPATION	EDUCATION/ GRADE
father					
step-father					
mother					
step-mother					
child					
child					
child					
child					

Are there significant marital conflicts? Yes _____ No _____

Are there significant conflicts between child and parent? Yes _____ No _____

Are there significant conflicts between your children? Yes _____ No _____

Do parents agree on how to discipline your child? Yes _____ No _____

Who disciplines and how? _____

How does your child respond to discipline? _____

PREGNANCY:

Is this child adopted? No _____ Yes _____

Did you have any of the following complications during this pregnancy? If so, indicate which month.

Anemia _____ High Blood Pressure _____

Swollen Ankles _____ Kidney Disease _____

Heart Disease _____ German Measles _____

Toxemia _____ Staining _____

Bleeding _____ Vomiting _____

Virus _____ Threatened miscarriage/early contractions _____

Rh or other blood incompatibility _____

List any other complications you may have had: _____

List any chronic illness (s) such as diabetes, kidney infection, thyroid problem, etc. you were suffering from during pregnancy: _____

List any other illnesses suffered during this pregnancy: _____

List any hospitalizations during this pregnancy (date and reason): _____

List any surgeries during this pregnancy: _____

List any injuries suffered during this pregnancy: _____

List any medications taken during this pregnancy: _____

BIRTH HISTORY OF THIS CHILD:

Name of hospital: _____

Hours from first contraction to birth: _____

List any medication (s) administered and why: _____

Name any anesthesia administered during childbirth: _____

Was labor induced? Yes ___ No ___

If yes, how and why? _____

Was your baby born head first? Yes ___ No ___ Don't Know ___

Were forceps used? Yes ___ No ___ Don't know ___

If yes, why?: _____

Did you have a cesarean section? Yes ___ No ___ If yes, why? _____

Did your baby have any bruises? Yes ___ No ___ If yes, where? _____

Did your baby have any birthmarks: Yes ___ No ___ If yes, where? _____

Was this a multiple birth? Yes ___ No ___ If yes, how many? _____

Did your baby have breathing problems? Yes ___ No ___ Don't know ___

Was the cord around the neck? Yes ___ No ___ Don't know ___

Did your baby cry quickly? Yes ___ No ___ Don't know ___

Was your baby's color normal? Yes ___ No ___ Don't know ___ Blue? ___ Yellow? _____

If your baby's color was yellow (jaundiced), did he/she receive any of the following?

Oxygen Yes ___ No ___ How long _____

Transfusions Yes ___ No ___ How many _____

Phototherapy Yes ___ No ___ How long _____

Were there any other complications before you took your baby home? Yes ___ No ___

If yes, what _____

Was your baby placed in an incubator or special crib? Yes ___ No ___ How long _____

How long after birth did you take your baby home? _____

EARLY HISTORY:

General:

Did your baby have feeding problems? Yes ___ No ___ If yes, describe them _____

Was your baby colicky? Yes ___ No ___ How long _____

Did your baby require formula changes? Yes ___ No ___ If yes, describe them _____

Did your baby have difficulty as an infant with the following?

Sucking ___ Chewing ___ Drooling past 2 1/2 months ___

Was your baby normally active? Yes ___ No ___

Was your baby limp? Yes ___ No ___

Was your baby stiff? Yes ___ No ___

Did your baby show unusual trembling? Yes ___ No ___ If so, when _____

As an infant or a toddler did your child have poor muscle control (i.e., weakness)? Yes ___ No ___

If yes, which of the following: Neck ___, Trunk ___, Legs ___, Chest ___, Arms ___, Fingers ___

Did your baby fail to grow normally? Yes ___ No ___

Did your baby fail to gain weight? Yes ___ No ___

Was this baby different in any way from his/her siblings? Yes ___ No ___

Describe how _____

Toileting:

Indicate your child's development by circling one description.

Toilet trained Early Average (13-36 mos.) Late

Did your child have enuresis (bedwetting)? Yes _____ No _____

If so, at what age did it start? _____ Age it was controlled: _____.

Did your child have urine accidents during the day? Yes _____ No _____

Did your child have soiling? Yes _____ No _____

Motor Milestones:

At what age did your child:

Sit alone _____ Pedal tricycle _____ Swim.. _____

Tie shoes _____ Ride bicycle _____

Walk without holding on _____ Dress self _____

Feed self _____

Which hand does your child prefer? Right _____ Left _____ Age established _____

Does your child switch hands? Yes _____ No _____

Indicate your child's development by circling one description.

Crawled early Early Average (6-9 mos.) Late

Walked alone (2-3 steps) Early Average (9-18 mos.) Late

Language Milestones:

At what age did your child:

Speak first words _____ Put 2-3 words together _____ Sentence structure _____

Speech problems? Yes _____ No _____ If yes, describe _____

Indicate your child's development by circling one description.

Followed simple commands Early Average (12-18 mos.) Late

Used singles words/sentences Early Average (12-24 mos.) Late

MEDICAL HISTORY

What is your child's height? _____ ft. _____ in. Weight? _____ lb.

Has your child ever had high or prolonged fevers? Yes _____ No _____

Did your child have frequent ear infections? Yes _____ No _____

If yes, were tubes placed? Yes _____ No _____

Does your child have any visual defects? Yes _____ No _____

Does your child have any hearing defects? Yes _____ No _____

Has your child broken any bones? Yes _____ No _____

Does your child frequently complain of any of the following:

Headache _____ Stomachaches _____ Trouble with vision _____

Dizziness _____ Chronic constipation _____

Weakness _____ Chronic diarrhea _____

Nausea _____ Trouble with hearing _____

Has your child ever had a temperature of 104° (40° C) or higher for more than a few hours?

Yes _____ No _____ If yes, what age or ages? _____

How long did it last? _____

Did your child ever have a seizure due to a fever or unknown cause? Yes _____ No _____

If yes, describe (age, nature of the seizure). _____

Did your child ever eat paint, paper, etc.? Yes _____ No _____

Has your child ever accidentally swallowed any poison, drug, or non-food object? Yes _____ No _____

If yes, what age (s)? _____ Describe _____

Has your child ever participated in team sports or other competitive sports? Yes ____ No ____

If yes, which ones? _____

Has your child ever been dazed ("dinged," "bell rung") or knocked unconscious while involved in sports? Yes ____ No ____

If yes, please describe _____

Has your child ever suffered a brain injury in an accident or assault? Yes ____ No ____

If yes, please describe _____

What time does your child typically go to bed? _____

What time does your child typically arise? _____

Does your child have any trouble falling asleep? Yes ____ No ____

Does your child have any trouble staying asleep throughout the night? Yes ____ No ____

Does your child sleepwalk? Yes ____ No ____

Does your child snore? Yes ____ No ____

Does your child have trouble with excessive movement when sleeping, such as "restless legs"?

Yes ____ No ____

Does your child have trouble with nightmares? Yes ____ No ____

Please check the following diseases and/or conditions that your child has had:

- | | | |
|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Metabolic disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Enzyme deficiency | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Genetic disorder | <input type="checkbox"/> Oxygen deprivation |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Heart disorder | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Brain stroke | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Kidney disorder | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Lung disorder | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Colds (excessive) | <input type="checkbox"/> Measles | <input type="checkbox"/> Other problems |

What therapies have been provided to your child?

- | | |
|---|---|
| <input type="checkbox"/> No therapies | <input type="checkbox"/> Speech therapy |
| <input type="checkbox"/> Occupational therapy | <input type="checkbox"/> Chiropractic treatment |
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Vision therapy |
| <input type="checkbox"/> Psychological therapy (counseling) | <input type="checkbox"/> Biofeedback |
| <input type="checkbox"/> Cognitive rehabilitation services | <input type="checkbox"/> Homeopathic treatments |

Did anyone in your immediate family or other relative have any of the following? If so, who?

- | | | | |
|-------------------------------------|----------|---------|---------------------|
| Problems similar to your child | Yes ____ | No ____ | Who _____ |
| Neurological disease | Yes ____ | No ____ | Who _____ |
| Seizures (epilepsy) | Yes ____ | No ____ | Who _____ |
| Emotional problems | Yes ____ | No ____ | Who _____ |
| Mental retardation | Yes ____ | No ____ | Who _____ |
| Hyperactivity | Yes ____ | No ____ | Who _____ |
| Learning problems | Yes ____ | No ____ | Who _____ |
| Reading or spelling difficulties | Yes ____ | No ____ | Who _____ |
| Speech or language problems | Yes ____ | No ____ | Who _____ |
| Does any disease run in the family? | Yes ____ | No ____ | If yes, what? _____ |

MEDICATION HISTORY:

List any medications your child is currently taking (including dosage and reason): _____

List any medications that your child has taken in the past for more than a month (including dosage and reason): _____

Has your child ever had a bad reaction to any medication? Yes ___ No ___ If yes, describe. _____

SCHOOL HISTORY:

Does your child like school? Yes ___ No ___

Did your child attend nursery school or a preschool program? Yes ___ No ___

If yes, age started _____. Were there any problems? Yes ___ No ___ If yes, describe: _____

Did your child attend 1st grade? Yes ___ No ___ If yes, age started: _____

Were there any problems? Yes ___ No ___ If yes, describe: _____

Has the school currently reported problems with:

Reading _____	Spelling _____	Following directions _____
Arithmetic _____	Behavior _____	Social adjustment _____
Attention span _____	Writing _____	

Has any psychological testing been done at school? Yes ___ No ___

If so, where, when and by whom? _____

What recommendations were made? _____

Has your child ever been held back or repeated a grade? If yes, which grade (s) and for what reason? _____

Does your child receive any special services in school (placement in special classroom, resource room, tutoring, remedial reading, OT, speech, reading services, etc.)? Yes ___ No ___ If yes, what services and for how long? _____

If not now, has your child ever been in a special class or provided with special services under an IEP or 504? Yes ___ No ___ If yes, describe. _____

Have you obtained any academic help privately for your child? Yes ___ No ___ If yes, indicate what type, when, by whom and how often: _____

What grades has your child mostly received in the past year? A's & B's ___ B's & C's ___
C's & D's ___ D's & F's ___ Outstanding ___ Good ___ Satisfactory ___ Improvement
needed ___ Unsatisfactory ___

Are these grades changed from the previous years? Yes ___ No ___

In which subject does your child do best? _____ Have the most difficulty? _____

In the past year has your child been absent from school due to illness or injury?

Less than 2 weeks ___ 2-4 weeks ___ 5-8 weeks ___ Over 8 weeks ___

Briefly describe the reasons for your child's absence. _____

BEHAVIOR AND SOCIAL HISTORY:

Does your child have difficulty getting along with children his/her own age? Yes ____ No ____

Does your child have difficulty getting along with adults? Yes ____ No ____

Does your child have problems making friends in school? Yes ____ No ____

Does your child have problems getting along with teachers? Yes ____ No ____

Does your child tend to get sick in the morning before school? Yes ____ No ____

Does your child get disciplined frequently at school? Yes ____ No ____

How does your child occupy his/her time? _____

How does your child perform athletically? _____

Has your child had emotional, adjustment, or behavioral problems? Yes ____ No ____

Has your child received any psychological or psychiatric treatment? Yes ____ No ____

If yes, when, where and by whom? _____

In addition to this history form, the additional information which was requested during the initial telephone conversation would also be helpful. This includes your child's birth and medical records if relevant; and preschool and/or school records, including evaluation reports by school personnel. If your child has had any evaluations outside of the school, we would appreciate copies of those, as well.

Additional comments: