BAYCARE CLINIC®
NEUROPSYCHOLOGY

Child / Adolescent Neuropsychological History Questionnaire

Confidential

The purpose of this questionnaire is to gather information about your child's history and present situation so that we may provide the most appropriate clinical services. Please answer each question as honestly and accurately as possible. (No one will be allowed to see your child's records without your permission).

General Information:

Child's Name: _____ Date: _____

[Completed By: _____ Relationship to Child: _____]

With whom does the child reside? (Please circle one):

Natural Parents | One Parent Alone | Parent & Step-Parent
Foster/Adoptive Parents | Legal Guardian | Other (specify): _____

Parents are (Circle one): Married Separated Divorced Widowed Unmarried

Place of Birth: _____

Gender: ☐ Female ☐ Male

Handedness: ☐ Right ☐ Left ☐ Both

Father's Information:

Name: _____ Date of Birth: _____
Occupation: _____ Highest grade completed in school: _____
Work Phone: _____ Home Phone: _____

Mother's Information:

Name: _____ Date of Birth: _____
Occupation: _____ Highest grade completed in school: _____
Work Phone: _____ Home Phone: _____

Step-Parent's Information (If applicable):

Name: _____ Date of Birth: _____
Age of child when step-parent entered family: _____
Occupation: _____ Highest grade completed in school: _____
Work Phone: _____ Home Phone: _____

The Problem:

For what current problem/symptoms are you seeking clinical services? _____

_____

_____

How long has your child had these problems? _____

Have these problems gotten worse over time? ☐ Yes ☐ No

Do both parents agree about the nature of your child's problems? ☐ Yes ☐ No

What other types of treatment / evaluations has your child had? _____
_____
_____

Has your child had any of the following (check all that apply)?

Neuro. Exam	____	Evoked Potentials	____
Spinal Tap	____	Angiogram	____
CT Scan	____	Myelogram	____
EEG	____	EMG	____
X-rays	____	CT	____
MRI	____	Other _____	

If yes, what were the results? _____
_____

Functional Changes (check all that apply)**:**

Physical Functioning

Weakness/Hemiplegia	_____	Coordination	_____	Fatigue	_____
Headaches	_____	Vision (R/L)	_____	Hearing (R/L)	_____
Somatosensory/Pain	_____	Appetite (Wt. Loss)	_____	Sleep	_____

Cognitive Functioning

Orientation	_____	Memory	_____	Speech	_____
Attention/Comprehension	_____	Organization	_____	Planning	_____

Personality/Interpersonal Relationship Changes

Personality Change	_____	Sexual Functioning	_____
Conduct/Behavior Problem	_____	Social Skill	_____
Insight/Awareness	_____	Affect/Mood	_____

Current Functional Status:

Please rate the following as Dependent (D), Needing Assistance (A), or Independent (I):

Bathing	_____	Grooming (Hair/Teeth/Shave)	_____
Walking (Gait/Balance)	_____	Stairs (Number)	_____
Eating (Swallowing)	_____	Preparing Meals	_____
Toileting	_____	Incontinence (Bladder/Bowel)	_____
Dressing	_____	Other/Special Needs	_____

Medical History:

Has your child ever had any of the following general medical problems:

Ear Infections?.....	☐ Yes	☐ No
Slow Weight Gain?.....	☐ Yes	☐ No
Allergies?.....	☐ Yes	☐ No
Up-to-date Immunizations?.....	☐ Yes	☐ No

Please specify any surgeries your child has had performed: _____
_____

Medications:

Please list all current prescribed medications (including dosages): _____

_____

Please list any over-the-counter medications your child is taking currently: _____

_____

Please list any relevant previously prescribed medications: _____

_____

Neurological History:

Has your child ever had any of the following neurological problems:

Head Injury with loss of consciousness?…….....	☐ Yes	☐ No
Head Injury without loss of consciousness?…….....	☐ Yes	☐ No
Dazed , Confused, or Disoriented?……	☐ Yes	☐ No
Heat Exhaustion/Sunstroke?.....	☐ Yes	☐ No
Partial drowning?.....…….....	☐ Yes	☐ No
Overcome by gases or fumes? .....……	☐ Yes	☐ No
Electrical or chemical shock?.....	☐ Yes	☐ No
Fainting or dizzy spells?.....	☐ Yes	☐ No
High Fever (over 103 degrees)?.....	☐ Yes	☐ No
Lead or other poisoning?.....	☐ Yes	☐ No

Please specify any other neurological problems: _____

Social Functioning:

Is your child involved in extracurricular / social activities: ☐ Yes ☐ No

What do you think of your child's friends? _____

_____

How well does your child form / maintain friendships / relationships with others?

Children own age: _____

Older Children: _____

Younger Children: _____

Opposite Sex: _____

School/Work: _____

Adults/Authority Figures: _____

Family: _____

Any anticipated changes in your child's support system? _____

_____

Family Medical History:

Has your child or any of his/her relatives had any of the following conditions? (Relatives include your child's biological parents, brothers and sisters, grandparents, aunts, uncles, and cousins.)

CONDITION	Child	Mother	Father	Sibling	Grandparent	Other
Hyperactive						
Behavior problems						
Reading difficulty						
Writing difficulty						
Math difficulty						
Speech problems						
Slow development						
Deformities						
Depression						
Anxiety or Panic Attacks						
Bipolar Disorder						
Tic Disorder						
Heavy drinking						
Drug abuse						
Overdose						
Mental retardation						
Cerebral palsy						
Brain hemorrhage						
Brain tumor						
Encephalitis, meningitis,						
Convulsions, Seizures,						
Severe headaches						
Muscular weakness						
Thyroid disease						
Heart disease						
Stroke						
Diabetes						
Anemia						
Rheumatic Fever						
Cancer						
Asthma						
Kidney / Bowel						
Early deaths/Miscarriages						

Please specify any other relevant family medical history:_____

Hearing:

Has your child ever been diagnosed with a hearing impairment? ☐ Yes ☐ No

If yes, please specify: _____

Has your child been prescribed a hearing aid? ☐ Yes ☐ No

If yes, does he / she wear it regularly? ☐ Yes ☐ No

Vision:

When was your child's last eye exam? _____

What were the results of that exam? _____

Has your child been diagnosed with any visual impairment? ☐ Yes ☐ No

If yes, please specify: _____

Sleep:

Please specify your child's typical sleep pattern (time to fall asleep, time to rise, amount of sleep per night):

_____

Does your child have any difficulty falling asleep, staying asleep, snoring/snorting, unpredictable length of sleep, early riser, very heavy sleeper, nightmares, night terrors, sleep walking, talking in sleep, etc.?

____ Yes _____ No (If yes, please specify: _____)

Has there been any recent change in your child's sleep habits? ☐ Yes ☐ No

If yes, please specify: _____

Eating:

Does your child eat a healthy diet from all four food groups? ☐ Yes ☐ No

Does your child have any strange eating habits? ☐ Yes ☐ No

Any recent change in your child's eating habits or appetite? ☐ Yes ☐ No

If yes, please specify: _____

_____

Any recent change in your child's weight? ☐ Yes ☐ No

If yes, please specify (gain, loss, how much, over what period of time): _____

_____

Habits:

Substance Use:

Does your child smoke cigarettes? ☐ Yes ☐ No

If yes, how much your child smokes per day: _____

Does your child use alcohol? ☐ Yes ☐ No

Does your child use illicit substances? ☐ Yes ☐ No

Does your child abuse prescription medications? ☐ Yes ☐ No

If yes, please specify: _____

_____

Developmental History: _____ Biological _____ Adopted

How many siblings does your child have? _____ Brothers _____ Sisters

Your child's birth order? _____

Pregnancy: ☐ Uneventful ☐ Complicated

Baby was born: ☐ Full term ☐ Premature at _____ weeks gestation

Delivery: ☐ Vaginal ☐ Cesarean

Birth Weight (pounds & ounces):_____ Breast Fed: ☐ Yes ☐ No

Age of Mother at Delivery: _____ Age of Father at Delivery: _____

ABOUT THE PREGNANCY:			**ABOUT THE NEWBORN:**		
	YES	***NO***		***YES***	***NO***
Had previous miscarriages			Was a twin		
Had previous premature babies			Had trouble breathing		
Had a difficult pregnancy			Born with cord around neck		
Vomited often			Had to be resuscitated		
Had bleeding 1st 3 months			Needed oxygen		
Had bleeding 2nd 3 months			Born with any defects		
Had bleeding last 3 months			Had seizures (convulsions)		
Had an infection			Turned blue		
Was hurt during pregnancy			Got yellow (jaundice)		
Had increased blood pressure			Was jittery		
Had gestational diabetes			Was hypoglycemic		
Had other illness(es)			Had other illness		
Had to take medication			Was given medication		
Had a difficult delivery			In the hospital more than 3 days		
Labor was induced			In the hospital more than 7 days		
Had labor more than 12 hours			Had trouble sucking		
Had labor less than 2 hours			Vomited often		
Had Caesarean section			Had diarrhea		
Was put to sleep for delivery			Had skin problems		

If you answered yes to any of the above questions, please explain: _____

_____

_____

Developmental Milestones: When did your child?:	**Age**	**On Time / Early / Late**
Sit up without help		

Walk alone		
Speak first words (mama, dada)		
Put 2 words together		
Speak in 2 or 3 word sentences		
Use a spoon		
Begin to separate from mother easily		
Achieve complete DAY TIME dryness		
Achieve complete NIGHTTIME dryness		
Achieve complete bowel control		
Start to dress self		
Catch a ball		
Begin to tie shoelaces		
Ride a 2 wheel bike		
Recognize Letters / Numbers		
Recite the alphabet		
Count to 20		
Read to self		
Write his/her name		
Draw a stick figure		
Draw a person with a body		
Draw animals and scenes		

Current School: _____Current Grade: _____

Placement: ☐ regular ☐ special ed. (describe service): _____

Other Schools Attended:

Pre-School: _____

Kindergarten: _____

Grade School: _____

Junior High / Middle School: _____

High School: _____

Overall, how does your child perform in school? Grades? G.P.A.? _____

What is your child's BEST class? _____ WORST class? _____

How does s/he manage homework? _____

Has your child ever skipped a grade? ☐ Yes ☐ No

Has s/he ever received an academic award, or been told s/he is gifted? ☐ Yes ☐ No

Has s/he repeated a grade, had a tutor, been in special ed or summer school?: ☐ Yes ☐ No

Has your child ever had an individual IQ test? ☐ Yes ☐ No

If Yes, what was the name of the test, reason, and results: _____

How far do you expect your child to go in school? _____

Psychological History:

Has your child ever been treated as an outpatient for psychological / emotional problems? ☐ Yes ☐ No

If yes, please specify when, the diagnoses, who treated, and the type of treatment:_____

Has your child ever been hospitalized for psychological / emotional problems? ☐ Yes ☐ No

If yes, please specify when, the diagnoses, who treated, and the type of treatment:

_____

If applicable, briefly describe any current psychological or emotional problems: _____

_____

Does your child (or has your child ever) had problems such as:	***YES***	***NO***
Repetitive habits?		
Rocking?		
Head banging?		
Thumb sucking?		
Nervous twitches or tics?		
Temper tantrums?		
Self-destructive behavior?		
Difficulty adhering to a schedule?		
Unwillingness to go along with change in daily routine?		
Shyness / bashfulness with strangers?		
Lying, stealing, cheating?		
Fire setting or cruelty to animals?		
Trouble with the neighbors, teachers, or law enforcement?		
Sadness?		
Worry?		
Fear of new people, places, or activities?		
Fear of being alone?		
Difficulty being consoled?		
Little or too much desire to be held?		
Mind or body overactivity?		
Impulsivity?		
Inattentiveness?		
Extreme reaction to noise or sudden movement?		
Sensory sensitivity?		
Many complaints of headaches, stomachaches, or other medical concerns?		

Is your child under any particular stress at this time? ☐ Yes ☐ No

If yes, please specify: _____

_____

What are your child's particular strengths? _____

_____

What are your child's hobbies, interests, recreational / leisure activities?_____

Any additional comments or concerns: _____

_____

_____

_____