childneuropsychology pc

Pediatric Questionnaire

Child's name ______________________________ Date of Birth ___________________ Age ____ Grade _______

Date form completed __________________________ Gender _____ M _____ F _____ Transgendered

Parent names _________________________________ *Second Household*: **Parent names** ____________________________

Address: _______________________________________
____
____

Address: _______________________________________
____
____

Home Phone ___________________ Cell phones: Parent _______________________ Parent ___________________________

Person completing form __________________________________ Relationship to child _________________________________

School ____ Phone ___________________________________

Address ____

Teacher(s) ____

Referral Information

Who referred you? ____ Professional's phone Number __________________________

What services are you seeking:
___ Neuropsychological Evaluation ___ School Entrance Evaluation ___ Cogmed Other _______________________

Family History

Parent name _____________________________________

Occupation _____________________________________
Employer _____________________________________

Highest grade completed _____________________________

Parent name _____________________________________

Occupation _____________________________________
Employer _____________________________________

Highest grade completed _____________________________

Are parents married to one another? ___ Yes ___ No If not, who has legal custody? ____

How often does child see non-custodial parent? ____

Step Parent name _________________________________
Occupation _________________________________
Employer _________________________________
Highest grade completed ___________________________

Step Parent name _________________________________
Occupation _________________________________
Employer _________________________________
Highest grade completed ___________________________

Who lives with this child? Please give name, age, and relationship (e.g., sibling, grandparent)
____
____
____

How does your child get along with family members? Who does he/she get along with best?
____
____
____
____

What activities do you enjoy as a family? ____
____
____

Important relatives outside of the home: ____

In the past 12 months, has your family experienced any of the following: ___ Move ___ Serious illness/injury
___ Death of a family member ___ Unemployment ___ Marital problems ___ Sibling difficulties ___ Other

Please explain: ____
____

Please explain if your child has been separated from you unexpectedly or for a protracted time (e.g.: hospitalization; military service; job duties)
____

Who cares for your child in your absence? ____

Is there a family history of: (check all that apply):

___ Learning Differences
___ Autism Spectrum Disorder
___ Anxiety
____Poor emotional/behavioral regulation
____ Attention Deficit/Hyperactivity Disorder
____ Neurologic condition (seizures, Tourette's, tics)
____ Depression
____ Chronic mental/physical health issue
_____ Other

Please explain: ____
____
____

Is there a history of trauma, including domestic violence, unexpected separation, abuse, chemical dependency ________ Yes _______ No
Please explain ____
____

Family Activities and Social Relations

What are the most enjoyable things about raising this child? ____
____
____

What are the most challenging things about raising this child? ____
____
____

Please explain ways you need to plan for or accommodate to your child's unique style? ____
____
____
____
____

Do both parents agree on discipline? _____ Yes _____ No Who usually disciplines the child? _____ Mom _____ Dad ____ Both

Please describe your discipline techniques. Are they effective? ____
____
____

Please explain any unusual parental issues or marital disagreements that may be affecting your child: ____
____
____

What does your child do for fun? ____
____
____

Describe your child’s social relationships (e.g., does s/he make and keep friends; invited for playdates; get along with adults, peers, younger children)
____
____
____
____
____
____
____
____

Birth History: Adoption

Age at adoption: ______________ Adopted from: _____________________________ Does your child know his/her adoption status? ________

Known information about biologic influences (e.g., parent ages; health, learning, or emotional issues):________________________________

Known information about prenatal care, unusual psychosocial stressors or circumstances during pregnancy: ________________________________

Known information about post-birth care (e.g., orphanage, foster home): ________________________________

Please explain any contact you maintain with birth family: ________________________________

Describe your adoption experience: ________________________________

***** please provide any additional known information in the following section *****

Birth History: Pregnancy and Delivery

Was this a planned pregnancy? __ Yes __ No Did the mother receive regular medical care? __ Yes __ No

Please list any prescribed or over-the-counter medications used during pregnancy:________________________________-

Frequency of use during pregnancy: Alcohol ________________________________ Cigarettes ________________________________

Any complications during pregnancy (please check all that apply)?

- __ Difficulty in conception
- __ Measles
- __ Anemia
- __ x-rays during pregnancy
- __ Toxemia
- __ Excessive vomiting
- __ High blood pressure
- __ Gestational diabetes
- __ Abnormal weight gain
- __ Vaginal bleeding
- __ Maternal injury
- __ Emotional problems or challenges
- __ Other

Please explain: ________________________________

Age of mother and mood throughout pregnancy: ________________________________

Age of father and mood throughout pregnancy: ________________________________

Where was this child born? ____ Hospital Other: ________________________________

Was the child born at full term? ______ Yes If no, gestational age at birth ______ weeks Was labor induced? ________________________

How long was labor? __________________________ Kind of anesthesia during delivery: ________________________________

Were there any of the following complications at delivery?

- __ Forceps used
- __ Breech position
- __ Labor induced
- __ Cord around neck
- __ Fever
- __ Slow heart rate
- __ Supplemental oxygen required? If so, how long? ________________________________
- __ Cesarean delivery / Reason: ________________________________

Birth weigh:t ______ lbs. _____ oz. Apgar Scores _________ Length of stay (if hospital birth) Mother ____ days Child ______ days

Please describe any additional assistance your baby needed: ________________________________

Mother's condition at birth / additional assistance needed: ____
____

Did the mother experience post-partum depression ("baby blues") __ Yes __ No Treatment ______________________

Any additional comments: ____
____

Developmental History

What was the temperament of your child as a baby? ____

Were there any feeding or sleeping problems? ____

At what age did your child sleep through the night? ________________ Does he/she sleep in own bed? ________________

Any current challenges with sleep? ____

At what age was your child toilet trained? Daytime _____________ Nighttime _____________

Any challenges with toileting? ____
Any medical reasons for soiling/wetting? ____

At what age (month/year) did your child do the following:

___________	Turn over	_____________	Show interest in or attraction to sounds
___________	Sit alone	_____________	Point to show someone else
___________	Crawl	_____________	Understand first words
___________	Stand alone	_____________	Speak first words
___________	Walk alone	_____________	Speak in sentences
__________	Use a pencil or crayon	_____________	Speak so a stranger could understand him/her
___________	Ride a bicycle		

Compared to other children, do you feel that your child was ***slower*** or had ***difficulties*** in learning ...

	Yes	**No**	**Comments**
To talk	___	___	______________________
To understand language	___	___	______________________
To build with blocks/puzzles	___	___	______________________
To walk, skip or hop	___	___	______________________
To throw or catch	___	___	______________________
To manage fasteners (button, zip)	___	___	______________________
To draw/ tie shoes	___	___	______________________
To name colors/letters	___	___	______________________
To leave parents without a fuss	___	___	______________________
To control his/her temper	___	___	______________________
To sit still for stories/TV	___	___	______________________
To play or socialize with other children	___	___	______________________

What hand does your child use for writing/eating? ___ Right ___ Left ___ Both History of Left-handedness in family? ___ Yes ___ No

Please explain any exaggerated sensitivities your child has to noise/light/touch/texture: ______________________
____

Please explain any exaggerated emotional/behavioral responses your child has, ones that seem different from other children: ___________
____
____

Please check therapeutic services your child has received at school or in the community (Please provide dates):

___ Occupational Therapy ____________________	___ Speech/language therapy ____________________
___ Social Skills Training ____________________	___ Individual Educational Support ______________
____ ABA or behavioral Therapy ______________	____Psychiatric or mental health ______________
___ Developmental Pediatrician ______________	____ Other: ____________________

Please note any diagnoses your child was given by the above providers: ______________________________
____

Which have been most useful? ____
____

Medical History

Please explain any diagnosed medical/neurodevelopmental conditions your child has (age at diagnosis; treatment): ___________________________

List medications your child is currently taking or has taken in the past: ___________________________

List any serious accidents/injuries; hospitalizations or surgeries your child has experienced: (event or condition/ age at diagnosis or treatment): ___________________________

Please identify dates/ circumstances of any significant blow to the head/ concussion (including dates/age): ___________________________

Please identify the IMMEDIATE symptoms experienced by your child:

Immediate Symptoms:
____ Dizziness
____ Headache
____ Vomiting
____ Changes in vision
____ Loss of balance
____ Irritability
____ Loss of memory for event
____ Loss of consciousness / # minutes: ______________

Please report the results of medical exam or imaging (e.g., MRI or CT) and recommended treatment: ___________________________

Please explain any LINGERING symptoms (beyond 4 weeks): ___________________________

Please explain any neurologic conditions your child has (e.g., seizures, tic disorders, etc): ___________________________

Please explain history of any chronic medical condition: (e.g., frequent ear infections; vision problems; allergies; hearing impairment): ___________________________

Educational History

Age your child attended preschool? _____________ Did not attend preschool __________ Age Entered Kindergarten: ________________

What is your child's current grade in school? _________ If repeated a grade, which one: ___________________________

What subjects does your child do well in? ___________________________

What subjects are challenging for your child? ___________________________

Characteristics of your child's behavior around school/ homework (*check all that apply*):

____ Enjoys school, looks forward to going
____ Enjoys learning but doesn't like school
____ Works well and completes work in reasonable time
____ Works well but takes a long time to finish
____ Needs help getting started
____ Needs help staying focused
____ Gets done only if we supervise
____ Rarely finishes homework assignments
____ Does not know homework assignments
____ Seems to forget things from day to day
____ Perfectionism is a problem
____ Good at projects / poor at tests
____ Grades effected by missing assignments
____ Has big emotional reactions that are hard to manage
____ Homework behavior stresses the whole family
____ Work is of inconsistent quality

Comments: ___________________________

Please explain any recent changes, adjustment or learning issues at this time: ___________________________

Please identify special education assistance your child receives at school:

___ IEP (Individual Education Program)
___ 504 Plan
___ Resource Room for: ______________________________
____ Classroom Aide
____ OT/Speech-Language/PT

Your child qualified for special education under which category:

____ Other health impaired
____ Learning Difference
____ Autism Spectrum Disorder
____ Emotional/Behavior Adjustment

Tutoring or special assistance your child receives/received outside of school: ______________________________

Dates/place/results of any previous evaluations. Diagnosed or suspected learning differences: ______________________________

What do teachers tell you about your child? ______________________________

You have answered many questions about your child and your family. What else do you think we should know?

Thank you for your help with this information.