Pediatric Neuropsychology History Form

The following information is considered confidential and privileged. Please answer all questions as well as you can.

Identifying Information	
Child's Name	
Date of Birth & Current Age &Grade	_____/_____/_____ Age: _____ Grade_____
Today's Date	_____/_____/_____
Person Completing This Form	
Relationship to the Child	
Referral Information	
What are your main concerns or the reasons for this evaluation?	
At what age was your child's problem first noted? By whom?	
Has your child ever received treatment for this problem? If yes, who saw the child? What happened?	
Family Information	
Home Address	Street Address: _____ _____ City: _____ State: _____ Zip: _ _ _____ Email Address:_____
Best Phone Number to Reach Parent(s)	
Parents' Names & Other Information Parent: _____	Age: _____ Education: _____ Occupation: _____ Work Title: _____ Employer: _____

Family Information	
Parent: _____	Age: _____ Education: _____ Occupation: _____ Work Title: _____ Employer: _____
The Child Is:	☐ Natural ☐ Adopted ☐ Foster
The Child's Parents Are:	☐ Married ☐Divorced ☐Separated ☐ Never Married ☐Domestic Partners
Please list all brothers and sisters, including full, half and step-siblings.	*Living with Child ?* Name: _____ Age: _____ ☐ Yes ☐ No Name: _____ Age: _____ ☐ Yes ☐ No Name: _____ Age: _____ ☐ Yes ☐ No
Please list anyone else living in the child's home, and indicate their relationship to the child.	
Are there any significant stressors or pressures on the family?	
Is there any family history of mental health problems? If yes, please describe.	
Pregnancy and Birth History	
Mother's age and number of this pregnancy	Age: _____ Mother's Pregnancy ☐ First ☐ Second ☐ Third __ th
1) Did the child's birth mother have any health problems during her pregnancy with the child? If yes, please describe. 2) Did the child's birth father have any significant health or mental health history?	
During the pregnancy did the mother?	Drink Alcohol? ☐ Yes ☐ No Smoke? ☐ Yes ☐ No Use Drugs? ☐ Yes ☐ No
The baby was born	☐ Full Term ☐ Premature (_____ weeks early)
How was the child born?	☐ Vaginal Delivery ☐ Cesarian Section
Did the baby breathe on his/her own right away?	☐ Yes ☐ No

Pregnancy and Birth History	
Apgar Scores (if known)	_____ One Minute _____ Five Minutes
Were any delivery complications or birth defects noted? If yes, please describe.	☐ No
Were forceps used in the delivery?	☐ Yes ☐ No
What was your child's birthweight	
How soon after birth was the baby discharged from the hospital?	
Any problems in the first year of life? If yes, please describe. Did the baby have to return to the hospital during his/her first year of life? If yes, why?	☐ No ☐ Yes ☐ No
Motor	
At what age did the child	Sit Up: _____ Crawl: _____ Walk: _____
Was the child slow to develop motor skills or awkward in comparison to his/her brothers and sisters?	☐ Yes ☐ No
Handedness	☐ Right ☐ Left ☐ Both
Family history of left-handedness? If yes, please list left-handed relatives.	
Has the child ever had Occupational Therapy (OT) or Physical Therapy (PT)? If yes, please explain.	☐ No
Language	
At what age did the child	Speak First Word: _____ Put 2-3 Words Together: _____
Any history of poor sucking, problems chewing or late drooling? If yes, please describe.	☐ No
Any history of speech delays or problems (e.g., difficult to understand, stuttering)? If yes, please describe.	☐ No
Has the child ever had Speech-Language Therapy? If yes, please describe.	☐ No
Any language other than English spoken in the home? If yes, please	☐ No

identify.	
Has the child ever lost developmental skills in any area? If yes, please describe.	☐ No
Toileting	
When was your child fully toilet trained?	
Any problems with bed wetting, daytime urine accidents, or soiling? If yes, please describe.	☐ No
Temperament & Social Development	
As a baby, was your child easy to comfort or soothe?	☐ Yes ☐ No
As a baby, did your child respond well to cuddling?	☐ Yes ☐ No
Any trouble getting along with other children his/her age? If yes, please describe.	☐ No
My child gets along best with	Children: ☐ Same age ☐ Younger ☐ Older *or* Adults ☐
Any difficulty getting or keeping friends? If yes, please describe.	☐ No
Does your child seem to understand social cues well (e.g., when others are angry or upset). If no, please describe.	☐ Yes
Child's Medical History	
Any problems with vision or hearing? If yes, please describe.	☐ No
Any problems with hearing? If yes, please describe.	☐ No
List any serious illnesses, injuries, hospitalizations or surgeries.	☐ None
(Check all that apply)	☐ Febrile Seizures ☐ Eating Difficulties ☐ Epilepsy ☐ Tics/Twitching

Child's Medical History	
	☐ Lead Poisoning ☐ Asthma/Allergies ☐ Loss of consciousness ☐ Abdominal pain/vomiting ☐ Headaches ☐ Frequent Ear Infections ☐ Sleep Difficulties ☐ Repeated movements ☐ Impulsivity ☐ Temper Tantrums ☐ Nail Biting ☐ Clumsiness ☐ Head Banging ☐ Self-Injurious Behavior
Describe any head injuries (e.g., date, what happened, changes in behavior after the injury).	
Current Medications & Their Reason	
Do any family members have a history of learning problems? If yes, please describe.	☐ No
Does anyone in the family have a problem similar to the child's? If yes, please describe.	☐ No
Has your child had contact with a social agency, psychiatrist, psychologist, clinic or private agency? If yes, please describe.	☐ No
Educational History	
Name of Child's School	
School's Address & Phone Number	Street Address: _____ City: _____ State: _____ Zip: __ _____ Phone: (_____) _____ - _____
Child's Grade in School	
Placement	☐ Regular Classes ☐ Resource Room ☐ Special Education Other: _____
Any grades repeated or skipped? If yes, please describe.	☐ No
The child's teachers report problems in: *(Check all that apply)*	☐ Reading ☐ Spelling ☐ Attention ☐ Concentration

Educational History

	☐ Arithmetic ☐ Writing	☐ Behavior ☐ Social Adjustment
Check if yourchild attended?	☐ Preschool	☐ Kindergarten
How many different schools has your child attended?		
My child's intelligence is likely	☐ Below Average ☐ Average ☐ High Average ☐ Superior	
Overall, I think my child is functioning like a child of what age?		

Consulting Professionals

Please list all others involved in your child's care, including pediatricians or other physicians, psychologists, social workers, counselors, therapists, or special educators.

Name/Profession	Nature of their Involvement
Name/Profession	Nature of their Involvement
Name/Profession	Nature of their Involvement
Name/Profession	Nature of their Involvement

Schools Please list the schools your child has attended since entering preschool.

Name	*Year Entered*	*Grades Attended*	*Length of Attendance*

Please list any additional comments to further explain your concerns. Feel free to use the back of this form or additional page.

Ellen S. Krantz, M.Ed., Ph.D.
Licensed Psychologist PSY16681
100 Tamal Plaza·Ste 102·Corte Madera, CA 94925-1125
(415) 927-3800·(415) 927-3809 (fax)

FACT SHEET

Child's Name_____

Parent's Name(s) _____

Address_____

_____

Alternate
Address_____

Telephone Numbers:

Home:_____ FAX:_____

_____ FAX:_____

Work: _____ FAX:_____

_____ FAX:_____

Cell: _____ Cell:_____

Email #1_____ Email # 2_____

School_____(phone) School FAX _____

Below please provide the name, phone number, and fax for all professionals with whom I may need to speak :

_____

_____

_____

_____

_____

_____