Developmental Neuropsychology Services, PLLC
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Neuropsychology Intake Questionnaire: Child Data Form

Child's Name:_____ Today's Date:_____

Birthdate:_____ Age:_____ Gender (circle one): Male Female Ethnicity:_____

Person filling out this form (circle one): Mother Father Stepmother Stepfather Other (please explain):_____

Parents / Guardians/ Family (Please circle Birth, Adoptive, or Foster)

Birth / Adoptive / Foster Mother's Name:_____ Education:_____

Birthdate:_____ Home Phone:_____

Home mailing address including zip code:_____

Employer:_____ Occupation:_____

Cell Phone:_____ Work Phone:_____

Birth / Adoptive / Foster Father's Name:_____ Education:_____

Birthdate:_____ Home Phone:_____

Home mailing address including zip code:_____

Employer:_____ Occupation:_____

Cell Phone:_____ Work Phone:_____

Stepmother's Name:_____ Education:_____

Birthdate:_____ Home Phone:_____

Home mailing address including zip code:_____

Employer:_____ Occupation:_____

Cell Phone:_____ Work Phone:_____

Stepfather's Name:_____ Education:_____

Birthdate:_____ Home Phone:_____

Home mailing address including zip code:_____

Employer:_____ Occupation:_____

Cell Phone:_____ Work Phone:_____

Other Guardian Name(s):_____ Education:_____

Birthdate:_____ Home Phone:_____

Home mailing address including zip code:_____

Employer:_____

Occupation:_____ Work Phone:_____

List all people living in household:

Name *Age* *Relationship to Child including biological, foster, or adoptive*

_____

_____

_____

_____

_____

If any brothers or sisters are living outside the home, list their names, ages, where they are living, and why they are no longer in your home:_____

_____

Primary language spoken in the home:_____

Other languages spoken in the home:_____

Referral Information

Briefly describe the child's current difficulties: _____

_____

_____

_____

How long has this been of concern to you? _____

What seems to help the situation? _____

_____

What seems to make this situation worse? _____

_____

Has the child received evaluation or treatment for the current issue or similar issues? Yes ____ No ____

If yes, when and with whom? _____

_____

Is the child on any medication **at this time**? Yes ____ No ____

If yes, list **current** medication (s), dosages, and name of professional monitoring your child's medication. Also indicate your child's response to the medications, both positive and negative effects.

_____

_____

_____

Who referred you for neuropsychological evaluation?

_____

What questions are you hoping this evaluation will answer? What information are you hoping to obtain?

_____

_____

_____

_____

What is important for those involved in testing your child to know about him or her?

_____

_____

_____

Describe the best things about your child: _____

_____

_____

_____

Have there been any major changes within the family life or the child's living situation that have affected your child's development (e.g., deaths, moves, divorces, loss of job, etc.)? ____ No ____ Yes (describe below)

EVENT DATE CHILD'S AGE

_____

_____

_____

_____

If parents are separated or divorced, who has physical custody of the child? _____

Who has legal custody?_____

How often does the other parent see the child (check one) N/A_____

Weekly or more often _____ Once or twice a month _____ Few times a year _____ Never _____

Pregnancy / Developmental History

Length of pregnancy (e.g., full term, 34 weeks, 30 weeks, etc.) _____

Length of delivery (number of hours from initial labor pains to birth): _____

Age of mother at pregnancy: _____

Please list any pregnancy/birth complications:_____

Child's birth weight:_____

Developmental Milestones

Please indicate the ages at which your child reached the following developmental milestones:

Smiled	_____	Sat without support	_____
Spoke first word	_____	Crawled	_____
Put two words together	_____	Stood without assistance	_____
Said sentences	_____	Walked without assistance	_____
Named colors	_____	Rode tricycle	_____
Told time	_____	Rode bicycle (no training wheels)	_____
Named coins	_____	Buttoned clothing	_____
Said alphabet in order	_____	Tied shoelaces	_____
Began to read	_____		

Bladder trained, day _____

Bladder trained, night _____

Bowel trained, day _____

Bowel trained, night _____

Any loss of bladder/bowel control after achieving initial control? If yes, explain:_____

Temperament

Please rate the following behaviors as your child appeared during infancy and toddlerhood:

Activity Level-How active has your child been from an early age?_____

_____

Distractibility-How easily was your child's attention diverted?_____

_____

Adaptability-How well did your child deal with transition and change?_____

_____

Approach/Withdrawal-How well did your child respond to new things (i.e., places, people, food, routines, etc.)?_____

_____

Intensity-Whether happy or unhappy, how aware were others of you child's feelings?_____

_____

Mood-What was your child's basic mood?_____

_____

Regularity-How predictable was your child in patterns of sleep, appetite, etc.?_____

_____

Sensory Threshold-Was your child over or under sensitive to light, sound, textures?_____

_____

Child's Medical History

Place a check next to any illness or condition that your son or daughter has had. When you check an item, also note the approximate date (or age) of the illness.

Check if yes	*Illness or condition or age(s)*	*Date (s)*	*Check if yes*	*Illness or condition*	*Date(s) or age(s)*
_____	Measles	_____	_____	Dizziness	_____
_____	German measles	_____	_____	Frequent or severe	_____
_____	Mumps	_____		headaches	
_____	Chicken Pox	_____	_____	Difficulty concentrating	_____
_____	Whooping Cough	_____	_____	Memory problems	_____
_____	Diphtheria	_____	_____	Extreme tiredness or	_____
_____	Scarlet fever	_____		Rheumatic fever	_____
_____	Encephalitis	_____	_____	Epilepsy	_____
_____	Fever over 104	_____	_____	Tuberculosis	_____
_____	Convulsions	_____	_____	Bone or joint disease	_____
_____	Allergy	_____	_____	Gonorrhea or syphilis	_____
_____	Hay fever	_____	_____	Anemia	_____
_____	PE Tubes	_____	_____	Jaundice/hepatitis	_____
_____	Broken bones	_____	_____	Diabetes	_____
_____	Hospitalizations	_____	_____	Cancer	_____
_____	Operations	_____	_____	High blood pressure	_____
_____	Ear problems	_____	_____	Heart disease	_____
	(disease, infection,		_____	Asthma	_____
	injury, or impaired hearing)		_____	Bleeding problems	_____
_____	Visual problems	_____	_____	Eczema or hives	_____
_____	Fainting spells	_____	_____	Suicide attempt	_____
_____	Pregnancy	_____	_____	Loss of consciousness	_____
_____	Paralysis	_____	_____	Other_____	_____
_____	Injuries to head	_____			

Please describe the head injury. Was there loss of consciousness? Did it require sutures? Did it result in a concussion, etc? _____

_____

Please describe other serious illnesses, need for stitches, or operations:

Illness / Operation *Age*

_____

_____

_____

Please list any medications your child has received in the past for medical concerns (psychological/behavioral problems will be discussed later). Also describe what sort of response (e.g., effective, slightly effective, not effective). Also list specific side effects, if any. Use the margins or additional paper if necessary.

Date Started	*Date Stopped*	*Medication*	*Dose*	*Response*	*Reason for Medication*
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Medical Care

Child's physician _____ Telephone _____

Physician's Mailing Address _____

How often does your son or daughter see a doctor? _____ Date of last visit_____

Has your son or daughter ever had psychological counseling or therapy? Yes _____ No _____

If yes, counselor's name_____

Counselor's Address_____

Telephone_____

Type of counseling and for what issues_____

When_____

Did you find it helpful? _____ No _____ Yes

Has your son or daughter ever attempted suicide? Yes _____ No_____

If yes, when?_____ How?_____

Please describe the circumstances that led up to the suicide attempt:_____

_____

_____

Did your son or daughter receive any therapy after this suicide attempt? Yes_____ No_____

Has your son or daughter ever talked about wanting to hurt him/herself? Yes _____ No_____

If yes, when?_____

Please describe the circumstances that led up to the suicidal ideation:_____

_____

_____

Did your son or daughter receive any therapy after talking about harming him/herself?

Yes_____ No_____

Has your son or daughter ever had a neurological exam? Yes _____ No_____

If yes, neurologist's name_____ Date of Exam_____

Neurologist's Address _____

Has your son or daughter ever had a psychiatric evaluation? Yes _____ No_____

If yes, doctor's name_____ Date of Evaluation_____

Doctor's Address _____

Reason for exam _____

Has your son or daughter ever been hospitalized in a psychiatric facility? Yes _____ No_____

If yes, when? _____ Where? _____

Reason? _____

Please list any and all diagnoses your child has been given (e.g., ADHD, Learning Disabled, PDD, Tourette's, Bipolar, Depression, Anxiety, Asperger's Disorder)

_____

_____

Please list any medications your child has received in the past **for psychological/behavioral problems**. Also describe what sort of response (e.g., effective, slightly effective, not effective). Also list specific side effects, if any.

Date Started	*Date Stopped*	*Medication*	*Dose*	*Response*	*Prescribing Physician*
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Social and Behavior Checklist

Place a check next to the following categories indicating whether you see this area as a strength or an area of concern for your son or daughter.

Strength	***Concern***		***Strength***	***Concern***	
_____	_____	Interactions with peers	_____	_____	Interactions with siblings
_____	_____	Anger management	_____	_____	Interactions with strangers
_____	_____	Activity level	_____	_____	Attention
_____	_____	Persistence	_____	_____	Planning activities, tasks
_____	_____	Energy level	_____	_____	Self-control
_____	_____	Problem solving	_____	_____	Discussing fears
_____	_____	Expressing feelings	_____	_____	Interaction with authority figures

Since age 5 has your child ever demonstrated the following: Check N/A _____ if your child is not yet 5.

_____ No _____ Yes	Anxiety or oversensitivity to new experiences
_____ No _____ Yes	Verbal aggression such as profanity, making threats and/or disruptive vocalizations
_____ No _____ Yes	Lack of attentiveness
_____ No _____ Yes	Wandering, running away, roaming
_____ No _____ Yes	Hyperactivity – inability to sit still or restlessness

_____ No _____ Yes Engages in compulsive rituals

If yes, please describe:_____

_____

_____ No _____ Yes Inability to make friends

_____ No _____ Yes Physical aggression such as hitting, biting, punching, kicking, spitting

_____ No _____ Yes Constant fighting with siblings or peers

_____ No _____ Yes Property destruction

_____ No _____ Yes Extreme withdrawal – social isolation – shyness

_____ No _____ Yes Sudden weight gain or loss

_____ No _____ Yes Eating objects which are not meant to be eaten

_____ No _____ Yes Self-injurious behavior such as head banging, head slapping, hair pulling, cutting

_____ No _____ Yes Nervous habits such as tics: If yes, please describe: _____

_____

_____ No _____ Yes Thumbsucking

_____ No _____ Yes Grinding teeth, clicking teeth

Please explain any "yes" responses:

_____

_____

_____

_____

Do you have concerns related to your child's ability to control their temper (i.e., tantrums)? Yes__ No__

If yes, please describe your concerns:_____

_____

_____

_____

Educational History

At what age did your child start going to school? _____

How did your child react to starting school? _____

School History: (please write in the names of the schools with the approximate dates of attendance)

Pre-school: _____ Dates:_____

Kindergarten:_____ Dates:_____

Elementary:_____ Dates:_____

_____ Dates:_____

Middle School:_____ Dates:_____

_____ Dates:_____

High School: _____ Dates:_____

_____ Dates:_____

Current School: _____ Current grade:_____

Current teacher or other school contact:_____ Phone:_____

Please check what you feel best describes your son / daughter in the following areas:

ATTENDANCE	**ABILITY**	**RELATIONS WITH CLASSMATES**	**BEHAVIOR**
Rarely absent	Above average	Above average	Above average
Sometimes absent	Average	Average	Average
Often absent	Below average	Below average	Below average

Place a check next to the following categories indicating whether you see the area as a strength or an area of concern for your son or daughter.

Strength / Concern			***Strength / Concern***		
_____	_____	Reading			Other subjects (list below)
_____	_____	Arithmetic	_____	_____	_____
_____	_____	Spelling	_____	_____	_____
_____	_____	Writing	_____	_____	_____
_____	_____	Relationship with teachers	_____	_____	_____

Has your son or daughter received any special education services (e.g., Title I, 504 accommodations, speech/language, adaptive physical education, occupational therapy, classroom aide, etc.)?

Yes_____ No_____

If yes, what type of service(s)?_____

When did the school last evaluate your child?_____

Has your son or daughter been retained a grade? Yes_____ No_____

If yes, which grade(s) and why?_____