CHILD NEUROPSYCHOLOGICAL HISTORY

Child's Name_____

Address (Street, City, ST, Zip)_____

Parent or guardian phone: (H)_____ (W)_____

Age_____ Birthdate_____ Religion_____

Sex_____ Ethnic or Racial Background_____

Grade and School_____

Special Placement (if any)_____

Hand child uses for writing or drawing: Right_____ Left_____ Switches between them_____

Primary Language _____ Secondary Language_____

Hand used for writing: (check one) Right hand_____ Left Hand_____

Medical diagnosis: (1) _____

(2) _____

(3) _____

(4)_____

Who referred the child for this testing?_____

Briefly describe the problem(s):

(1) _____

(2) _____

(3) _____

(4) _____

What specific questions would you like answered by this evaluation?

(1) _____

(2) _____

(3) _____

(4) _____

THIS FORM HAS BEEN COMPLETED BY:

Name_____ Relationship to child_____

Address_____

Phone (H)_____ (W)_____

SYMPTOM SURVEY

For each symptom that applies to the child, place a check in the box. Compare the child to other children of the same age. Then, check if this is a NEW symptom (within the past year) OR after the injury/illness or an OLD symptom (over one year OR before the injury or illness). Add any comments next to the item.

1) PROBLEM SOLVING

✓	New	Old	
☐	___	___	Difficulty figuring out how to do new things
☐	_____	_____	Difficulty making decisions
☐	_____	_____	Difficulty planning ahead
☐	_____	_____	Difficulty solving problems a younger child can do
☐	_____	_____	Disorganized in his/her approach to problems
☐	_____	_____	Difficulty understanding explanations
☐	_____	_____	Difficulty doing things in the right order (sequencing)
☐	_____	_____	Difficulty verbally describing the steps involved in doing something
☐	_____	_____	Difficulty completing an activity in a reasonable period of time
☐	_____	_____	Difficulty changing a plan or activity when necessary
☐	_____	_____	Is slow to learn new things
☐	_____	_____	Difficulty switching from one activity to another activity
☐	_____	_____	Easily frustrated
☐	_____	_____	Other problem solving difficulties_____

2) SPEECH, LANGUAGE, AND MATH SKILLS

✓	New	Old	
☐	___	___	Difficulty speaking clearly
☐	_____	_____	Difficulty finding the right word to say
☐	_____	_____	Not talking
☐	_____	_____	Rambles on and on without saying much
☐	_____	_____	Jumps from topic to topic
☐	_____	_____	Odd or unusual language or vocal sounds
☐	_____	_____	Difficulty understanding what others are saying
☐	_____	_____	Difficulty understanding what he/she is reading
☐	_____	_____	Difficulty writing letters or words
☐	_____	_____	Difficulty reading letters or words
☐	_____	_____	Difficulty with spelling
☐	_____	_____	Difficulty with math
☐	_____	_____	Other speech, language or math problems:_____

3) SPATIAL SKILLS

✓	New	Old	
☐	___	___	Confusion telling right from left
☐	_____	_____	Has difficulty with puzzles, Legos, blocks or similar games
☐	_____	_____	Problems drawing or copying
☐	___	___	Does not know his/her colors
☐	_____	_____	Difficulty dressing (not due to physical disability)
☐	_____	_____	Problems finding his/her way around placed he/she has been to before
☐	___	___	Difficulty recognizing objects
☐	_____	_____	Seems unable to recognize facial or body expressions of disapproval or emotions
☐	_____	_____	Gets lost easily
☐	_____	_____	Other spatial problems

4) AWARENESS AND CONCENTRATION

✓	New	Old	
☐	_____	_____	Easily distracted by: Sounds_____ Sights_____ Physical sensations_____
☐	_____	_____	Mind appears to go blank at times
☐	_____	_____	Loses train of thought
☐	_____	_____	Difficulty concentrating on what other say but can sit in front of a TV for long periods
☐	_____	_____	Attention starts out OK but cannot keep it up
☐	_____	_____	Other attention or concentration problems:_____

5) MEMORY

✓	New	Old	
☐	_____	_____	Forgets where he/she leaves things
☐	_____	_____	Forgets things that happened recently (e.g., last meal)
☐	_____	_____	Forgets things that happened days/weeks ago
☐	_____	_____	Forgets what he/she is supposed to be doing
☐	_____	_____	Forgets names more than most people do
☐	_____	_____	Forgets instructions
☐	_____	_____	Other memory problems:_____

6) MOTOR AND COORDINATION

✓	New	Old		Check the side this occurs on: Right	Left	Both Sides
☐	_____	_____	Poor fine motor skills (e.g., using a pencil or crayon)	_____	_____	_____
☐	_____	_____	Clumsy	_____	_____	_____
☐	_____	_____	Weakness	_____	_____	_____

☐	_____	_____	Tremor	_____	_____	_____
☐	_____	_____	Muscles are tight or spastic	_____	_____	_____
☐	_____	_____	Odd movements (posturing, peculiar head movements)	_____	_____	_____
☐	_____	_____	Drops things more than most children			
☐	_____	_____	Has an unusual walk			
☐	_____	_____	Problems running			
☐	_____	_____	Balance problems			
☐	_____	_____	Other motor or coordination problems:_____			

7) SENSORY

✓	New	Old		Check the side this occurs on: Right	Left	Both Sides
☐	_____	_____	Needs to squint or move closer to the page to read	_____	_____	_____
☐	_____	_____	Problems seeing objects	_____	_____	_____
☐	_____	_____	Loss of feeling			
☐	_____	_____	Problems hearing sounds			
☐	_____	_____	Difficulty telling hot from cold			
☐	_____	_____	Difficulty smelling odors			
☐	_____	_____	Difficulty tasting food			
☐	_____	_____	Overly sensitive to: Touch_____ Light_____ Noise_____			
☐	_____	_____	Other sensory problems:_____			

8) PHYSICAL

✓	New	Old		How Often?
☐	___	___	Frequently complains of headaches or nausea	_____
☐	_____	_____	Has dizzy spells	_____
☐	_____	_____	Has pain in joints. *Where?*_____	_____
☐	_____	_____	Excessive tiredness	
☐	_____	_____	Frequent urination or drinking	
☐	_____	_____	Other physical problems:_____	

9) BEHAVIOR

✓	New	Old	
☐	___	___	Aggressive
☐	_____	_____	Attached to things, not people
☐	_____	_____	Bedwetting
☐	___	___	Bizarre behavior
☐	_____	_____	Bowel movements in underwear

☐ _____ _____ Dependent

☐ ___ ___ Depressed

☐ _____ _____ Eating habits are poor

☐ ___ ___ Emotional

☐ _____ _____ Fearful

☐ _____ _____ Immature

☐ ___ ___ Nervous

☐ _____ _____ Nightmares, night terrors, sleepwalks

☐ _____ _____ Quiet

☐ ___ ___ Resists change

☐ _____ _____ Risk-taking

☐ ___ ___ Self-mutilates

☐ _____ _____ Self-stimulates

☐ _____ _____ Shy and withdrawn

☐ ___ ___ Sleeping habits are poor

☐ _____ _____ Swears a lot

☐ _____ _____ Unmotivated

☐ ___ ___ Other unusual behavior_____

Below, check all the descriptions of the child that have been present for at least the past 6 months. These behaviors should occur more frequently than other children of the same age.

_____ Careless
_____ Is easily distracted
_____ Has a hard time concentrating for long periods
_____ Rarely follows others' instructions
_____ Does not listen to other people
_____ Goes from one activity to another without finishing anything
_____ Seems like he/she frequently is losing things that are needed for school
_____ Forgetful in daily activities
_____ Seems disorganized
_____ Is very fidgety
_____ Cannot remain seated
_____ Cannot wait for his/her turn when playing with others
_____ Answers before he/she hears the whole question
_____ Frequently makes noise when playing
_____ Seems like he/she is always talking
_____ Is often rude or interrupts others
_____ Seems like driven by a motor

_____ Cannot seem to play quietly
_____ Frequently does dangerous things without considering the consequences
_____ Loses temper easily
_____ Argues with adults
_____ Refuses to comply with requests
_____ Easily blames others for mistakes and problems
_____ Easily annoyed or irritated
_____ Seems angry and resentful
_____ Steals things without people knowing on several occasions
_____ Often runs away form his parents' home and stays away overnight
_____ Easily lies to others
_____ Fire setting
_____ Does not go to school
_____ Breaks into other people's property
_____ Destroys other people's property in some manner other than by fire
_____ Is cruel to animals
_____ Has forcible sexual relations with others
_____ When fighting, has used a weapon on more than one occasion
_____ Starts fights with others
_____ Will steal directly from people
_____ Is cruel to other people

10) Overall, the child's symptoms have developed: _____ Slowly _____ Quickly
11) The symptoms occur: _____ Occasionally _____ Often
12) Over the past 6 months, the symptoms have: _____ Stayed about the same _____ Worsened

PREGNANCY

13) Mother's age at birth:_____ Father's age at birth:_____
14) **Before** the pregnancy, what medications (prescribed or over-the-counter) did the mother take?
List all medications used:_____
15) **While** pregnant, what medications (prescribed or over-the-counter) did the mother take?
List all medications used:_____
16) How often did the mother see her doctor during the pregnancy?
Regularly (as scheduled by the doctor)_____ Rarely_____ Not at all_____
17) During the pregnancy, which of the following did the mother use?

	Amount and Daily Frequency
_____ Alcohol	_____
_____ Caffeine (coffee, colas, etc.)	_____
_____ Marijuana	_____
_____ Recreational drugs (cocaine, heroin, etc.)	_____
_____ Tobacco	_____

18) During pregnancy, the mother's diet was: Good_____ Poor_____
If poor, explain:_____
19) The mother's general physical health during the pregnancy was: Good_____ Poor_____
If poor, explain:_____
20) About how much weight did the mother gain while she was pregnant? _____lbs.

21) During this pregnancy, check all the mother had:

_____ Accident
_____ Anemia
_____ Bleeding (severe or frequent spotting)
_____ Diabetes
_____ High blood pressure
_____ Illnesses or infections
_____ Preeclampsia, eclampsia or toxemia
_____ Psychological problems
_____ Surgery
_____ Vomiting (severe or frequent)

22) How many pregnancies did the mother have prior to this one?

Number of live births: _____
Number of miscarriages: _____
Number of abortions: _____

BIRTH

23) Was the child born:

Early _____ How early? _____ weeks
On time _____ (38-42 weeks)
Late _____ How late? _____ weeks

24) How much did the baby weigh at birth? _____lbs. _____ oz. OR _____gms.

25) How long did the labor last? _____

26) The labor was: Easy _____ Moderately difficult _____ Very difficult _____

27) What type of medication was the mother given to help with delivery? None_____

Demerol_____ Gas_____ Regional nerve (spinal) block_____ Tranquilizer_____ Epidural_____

28) Were forceps used during delivery? Yes_____ No_____

29) Was the baby born:

Head first _____ Transverse (crosswise) _____ Posterior first _____
Breech birth _____ Cesarean section _____ Vacuum extraction _____
Other:_____

30) Did the baby experience any of these problems?

Fetal distress_____ Low placenta (Placenta previa) _____ Prolapsed cord _____
Premature separation of the placenta (Abruptio placenta) _____

31) Describe any other special problems the mother or child had during delivery: _____
_____
_____

32) At birth, did the baby:

Have difficulty breathing? Yes_____ No_____
Fail to cry? Yes_____ No_____
Appear inactive? Yes_____ No_____

33) List the baby's Apgar scores: 1st_____ 2nd_____

34) If the father or mother noticed anything unusual when they first saw the baby, describe:_____
_____

_____

35) If the baby was born with any problems (congenital defects, large or small head, blue baby, bleeding in brain, etc.), describe:_____

_____

36) Describe any special problems that the baby had in the first few days or weeks following birth: _____

_____

_____

37) Describe any special care, treatment, or equipment the child was given after birth: _____

_____

_____

38) How long did the baby stay in the hospital?_____

DEVELOPMENTAL HISTORY

39) For each area, indicate the child's development by circling one description. The "Average" period is only a rough idea of what is average since every developmental milestone actually involves a range of several months (e.g., walking occurs approximately 9-18 months of age). Circle "Early" or "Late" only if you are sure the child's development was different from that of most other children.

GROSS MOTOR SKILLS

Crawled	Early	Average (6-9 months)	Late
Walked alone (2-3 steps)	Early	Average 9-18 months)	Late
Pedals a tricycle	Early	Average 26-32 months)	Late

LANGUAGAE

Followed simple commands	Early	Average 12-18 months	Late
Used single word	Early	Average 12-24 months	Late
Said phrases	Early	Average 24-36 months	Late
Names primary colors	Early	Average 36-48 months	Late

ADAPTIVE

Toilet trained	Early	Average 13-36 months	Late
Feeds self with spoon	Early	Average 21-24 months	Late
Takes off opens shirt/coat	Early	Average 18-24 months	Late

40) List any other significant developmental problems: _____

_____

_____

41) Overall, the child's development was:

Early_____ Average_____ Late_____

42) As an infant or toddler, did the child have poor muscle control (i.e., weakness) of the:

Neck_____ Trunk_____ Legs_____ Arms_____

43) As an infant or toddler, did the child's muscles seem to be unusually tight or stiff?

Yes_____ No_____ If yes, describe:_____

44) Toilet training was: Easy_____ Difficult_____

45) As an infant, to a significant degree, were any of the following present during the first two years of life?

Did not enjoy cuddling _____

Was not calmed by being held or stroked _____

Difficult to comfort _____
Colic _____
Excessive restlessness _____
Poor sleep _____
Head banging _____
Difficult nursing _____

46) 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 well did you child pay attention?_____

_____

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

_____

Approach/Withdrawal – How well did your child respond to new things (i.e., people and places)?

_____

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

Regularity – How predictable was your child in patterns of sleep, appetite, routines, etc? _____

_____

HEALTH HISTORY

47) Did the child have a good appetite as a baby? Yes_____ No_____

48) Did the child fail to gain weight steadily as a baby? Yes_____ No_____

49) List the baby's illness or physical problems during the first year: _____

_____

50) Has the child had a temperature of 104°F (40°C) or higher for more than a few hours? Yes_____ No_____

If yes, at what age(s)?_____ How long did it last?_____

51) Has the child ever been hit hard on the head or suffered a head injury? Yes_____ No_____

If yes, what age(s)?_____ Did the child lose consciousness? Yes_____ No_____

How did it happen?_____

What problems did the child have (physical or mental) afterward?_____

_____

52) Has the child been diagnosed with seizures or epilepsy?

If yes, which type? Partial seizure_____ Generalized seizure_____ Unclassified type_____

If medication is used, what medication(s)?_____

Has the child ever had a bad reaction to this medicine? Yes_____ No_____

If yes, describe:_____

Did the child ever have a seizure due to a fever or unknown cause? Yes_____ No_____

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

53) Was the child ever in the hospital for an accident, injury or operation? Yes_____ No_____

If yes, what age(s)_____ What happened?_____

_____

_____

54) Has the child lever swallowed any poison, non-food, or drug accidentally? Yes_____ No_____

If yes, what age(s)?_____ What happened?_____

55) Did the child have frequent ear infections? Yes_____ No_____

If yes, what age(s)?_____ How often and how severe?_____

What treatment was provided?_____

56) Please check all the following diseases or conditions the child has ever had:

_____ Allergies	_____ Cerebral Palsy	_____ Jaundice	_____ Mumps
_____ Anemia	_____ Chicken Pox	_____ Kidney disorder	_____ Oxygen deprivation
_____ Asthma	_____ Colds (excessive)	_____ Leukemia	_____ Pneumonia
_____ Bleeding disorder	_____ Diabetes	_____ Liver disorder	_____ Rheumatic fever
_____ Blood disorder	_____ Encephalitis	_____ Lung disorder	_____ Scarlet fever
_____ Brain disorder	_____ Enzyme deficiency	_____ Measles	_____ Tuberculosis
_____ Broken bones	_____ Genetic disorder	_____ Meningitis	_____ Venereal disease
_____ Cancer	_____ Heart disorder	_____ Metabolic disorder	_____ Whooping cough

_____ Eye problems _____ Tics (eye blinking, sniffing, and repetitive movement)

_____ Other problems:_____

57) As the child has been growing up, he/she has been sick:

_____Much of the time _____An average amount _____Not much at all

58) List all of the medications the child takes now:

Medication	Dosage	How often?	What for?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

59) Does the child?

Wear glasses Yes_____ No_____ Farsighted_____ Nearsighted_____ Other_____

Use a hearing aid Yes_____ No_____

60) Within the past year has the child had: RESULTS

A vision test? Yes_____ No_____ _____

A hearing test? Yes_____ No_____ _____

61) What is the child's: Height_____ ft. _____ in. Weight:_____ lbs.

62) When was the child's last medical checkup? _____

63) What therapies have been provided to the child? _____ No therapies

_____ Occupational therapy

_____ Physical therapy

_____ Psychological therapy, counseling, or cognitive rehabilitation

_____ Speech therapy

_____ Other therapy_____

FAMILY HISTORY

64) The child lives with:

_____ Biological parent(s) only _____ Relatives _____ Foster parents

_____ Biological parent and other _____ Adoptive parents _____ Institutional care

_____ Other placement_____

Please list all the people currently living in the home with the child and their relation to the child (include family and Non-family members)_____

_____

_____

65) The family income is:

_____ Under $10,000 _____ $10,000-29,999 _____ $30,000-50,000 _____ over $50,000

66) What is the name of the child's biological mother?_____

a. Is she living? Yes_____ No_____ If deceased, explain_____

b. Her age? _____

c. What is her level of education?_____

d. Her occupation?_____

If mother works outside the home, how many hours and what days?_____

e. Does she live in the same house as the child? Yes_____ No_____

f. How often does she see the child?_____

g. How involved is the mother in the child's upbringing? Very____ Somewhat_____ Not at all_____

h. During school, did the mother have:

Learning problems_____

Attention problems_____

Behavior problems_____

Medical problems_____

i. What are the mother's hobbies?_____

j. What is mother's primary language?_____ Secondary language?_____

67) What is the name of the child's biological father?_____

a. Is he living? Yes_____ No_____ If deceased, explain_____

b. His age? _____

c. What is his level of education?_____

d. His occupation?_____

If father works outside the home, how many hours and what days?_____

e. Does he live in the same house as the child? Yes_____ No_____

f. How often does he see the child?_____

g. How involved is the father in the child's upbringing? Very____ Somewhat_____ Not at all_____

h. During school, did the father have:

Learning problems_____

Attention problems_____

Behavior problems_____

Medical problems_____

i. What are the father's hobbies?_____

j. What is father's primary language?_____ Secondary language?_____

68) Please list the names, ages and grade (or job) of the child's brother and sisters:

Name	Age	Grade or Job	Medical, social, school problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

69) Has anyone in the child's biological family (including parents, grandparents, siblings, aunts, and uncles) ever had any of the following?

	Which relative	Describe the problem briefly
_____ Brain disease	_____	_____
_____ Developmental delay	_____	_____

_____ Epilepsy or seizures _____ _____

_____ Learning disability _____ _____

_____ Mental retardation _____ _____ _____

_____ Neurologic disease _____ _____ _____

_____ Psychological problems _____ _____ _____

_____ Reading/spelling difficulty _____ _____

_____ Speech/Language problems _____ _____

70) Which of the child's biological relatives are left handed? No one_____
Mother_____ Father_____ Sibling(s)_____ Grandparents_____

71) What languages are spoken in the home? (List in order of the most frequent first)
(1) _____ (2)_____

72) How is the child disciplined?_____
_____
Is the discipline effective?_____

73) List the child's usual recreational activities and hobbies:_____
_____
_____

74) Have there been any major family stresses or changes in the past year (e.g., moving with a change of school, divorce, significant illness, etc.)? Yes_____ No_____
If yes, explain:_____
_____
_____

75) Does the child attend daycare outside the home or does someone come into the home to provide the service? ___
_____
Does daycare provide any type of formal program of play, developmental, or academic activities? _____
_____
_____

PEER RELATIONSHIPS

76) Does your child seek friendships with peers?_____
_____

77) Is your child sought by peers for friendship?_____
_____

78) Does your child play with children primarily his or her own age? _____
Younger?_____ Older?_____

79) Describe any problems your child may have with peers:_____
_____

SCHOOL HISTORY:

80) The child's present school is: Name:_____
Address:_____
Phone:_____ Contact person:_____

81) Was the child ever held back to repeat a grade? Yes_____ No_____
If yes, which grade?_____ Why?_____
_____

82) Has the child ever been in a special class or provided with special services (e.g., RSP, self-contained day class, learning or language disability class, etc)? Yes_____ No_____
If yes, describe the special class:_____
_____
Is the child in this class or receiving special classes now? Yes_____ No_____
If yes, describe the present class placement:_____
_____

83) Does the child like school? Most of the time_____ Sometimes_____ Almost never_____

84) Does the child:
Have problems with other children in class? Yes_____ No_____
Have problems making friends in school? Yes_____ No_____
Have problems getting along with teachers? Yes_____ No_____
Tend to get sick in the morning before school? Yes_____ No_____

85) Describe the teacher's concerns about the child's schoolwork or behavior:_____
_____
_____

86) What kind of grades has the child received in the past year?
As and Bs_____ Bs and Cs_____ Cs and Ds_____ Ds and Fs_____
Or
Outstanding_____ Good_____ Satisfactory_____ Improvement needed_____ Unsatisfactory_____
Or
Other grading system_____
Are these grades a change from previous years? Yes_____ No_____
If yes, describe:_____
_____

87) In which subject(s) does the child do best?_____
_____

88) Which subject(s) are the most difficult?_____
_____

89) In the past year, how much school has the child missed due to illness or injury?
Less than 2 weeks_____ 2-4 weeks_____ 5-8 weeks_____ Over 8 weeks_____
Briefly describe the reasons if the child has missed a lot of school: _____
_____
_____

90) Does the child seem to have a "school phobia"? Yes_____ No_____
If yes, explain:_____
_____

91) Do you consider your child to understand directions and situations as well as other children his or her age? _____
_____
_____

92) How would you rate your child's overall intelligence compared to other children?
Below average_____ Above average_____ Average_____

PREVIOUS EVALUATIONS

93) Which of these tests or procedures have recently been done? Note if normal or abnormal.

Evaluation	Normal	Abnormal	Date
_____ Blood work	_____	_____	_____
_____ Family physician or pediatrician office visit	_____	_____	_____
_____ Hearing testing	_____	_____	_____
_____ Lead level check	_____	_____	_____
_____ Lumbar puncture or spinal tap	_____	_____	_____
_____ Neurological exam or testing (CT scan, EEG)	_____	_____	_____
_____ Psychological or Neuropsychological Testing	_____	_____	_____
_____ School testing	_____	_____	_____
_____ Speech & Language testing	_____	_____	_____
_____ Vision testing	_____	_____	_____
_____ X-rays	_____	_____	_____
_____ Other tests			
_____	_____	_____	_____
_____	_____	_____	_____

94) What are the names of the physician, psychologist, school authority, or other professionals who are most familiar with the child's problems?

Name_____ Name_____
Address_____ Address_____
_____ _____
Phone_____ Phone_____
Profession_____ Profession_____

Please note: If your child has seen a psychologist at any time in the last year for testing or treatment, please be sure to advise the doctor.

ADDITIONAL COMMENTS: Please note below any further information you feel may be helpful in the evaluation of your child._____
_____
_____
_____
_____
_____
_____

_____ _____

Parent or Guardian's Signature Date

THANK YOU FOR TAKING THE TIME TO CAREFULLY COMPLETE THIS QUESTIONNAIRE.

MEDICAL HISTORY

Patient's Name: _____

Date:_____

Have you suffered from any serious childhood illnesses: Yes No

If yes, which one(s):_____

Do you currently have or have had a history of any of the following conditions: (Circle all that apply)

Allergies	Herpes
Arthritis	High blood pressure
Asthma	Irritable bowel syndrome
Broken bones	Kidney disease
Bronchitis	Liver disease
Cardiovascular disease	Lupus
Cancer	Mental illness
Chronic pain	Pulmonary disease
Colitis	Seizures
Concussion	Stroke
Congenital abnormality	Thyroid disease
Diabetes	Tuberculosis
Emphysema	Ulcers
Gall stones	Other_____
Head Trauma	Other_____

Heart attack

Hemorrhoids

Is there any family (blood relative) history of serious disease? Yes No
If so, which one(s)?_____

Have you had any operations/surgical procedures? Yes No
If so, please list procedure(s) and year(s):_____
_____

Do you currently have or have you had a history of any of the following symptoms? (Circle all that apply)

Headaches	Dizziness	Loss of Balance
Blackouts	Fainting	Blurry Vision
Poor Vision	Poor Hearing	Noise in Ears
Congested Nose	Shortness of Breath	Sinus Problems
Sore Throat	Coughing	Rapid Heartbeat
Irregular Heartbeat	Heartburn	Burping
Nausea	Vomiting	Gas
Bloated Stomach	Constipation	Diarrhea
Urination Problems	Weakness	Menstruation Problems
Twitching	Trembling	Cramps
Numbness	Skin Problems	Hyperventilation
Sleep Problems	Poor Appetite	Overeat
Weight Loss	Weight Gain	Low Sexual Energy

Sexual Performance Problems Other:_____

Do you have any pains? Yes_____ No_____

If so, what body part?_____

List any prescription medications you take:_____
_____

Do you use drugs? Yes_____ No_____ If so, which ones?_____

Do you drink alcohol? Yes____ No_____ If so, how many times per month?_____

On an average, how many drinks do you consume when you have alcohol?_____

Do you smoke tobacco? Yes_____ No_____ If so, how much per day?_____

Have you ever had any mental health treatment? Yes_____ No_____

If yes, when treated and for what condition?_____

Is there any family (blood relative) history of mental illness? Yes_____ No_____

If so, which condition(s)?_____

13) You were born On time _____ Prematurely _____ Late _____

14) Your weight at birth: _____ lbs. _____ oz.

15) Mother's weight gain during pregnancy: _____ lbs.

16) Were there any problems associated with your birth (e.g., oxygen deprivation, unusual birth position, etc.) or the period immediately afterward (e.g., need for oxygen, special equipment used, convulsions, illness, etc.)

_____ Yes _____ No

If yes, describe:_____

17) Check all that applied to your mother while she was pregnant with you:

_____ Accident
_____ Alcohol use
_____ Cigarette smoking
_____ Drug use (marijuana, speed, cocaine, LSD, etc.)
_____ Poor nutrition
_____ Psychological problems
_____ Other problems: _____

18) List all the medications (prescribed or over-the-counter) your mother took while pregnant.

_____

19) During her pregnancy, did your mother live near a polluted area (e.g., toxic waste dump) or other hazardous area (nuclear plant, industrial area, pesticide sprayed area, etc.)? _____ Yes _____ No

If yes, describe:_____

20) Rate your developmental progress as it has been reported to you by checking one description for each area:

	Early	Average	Late
Walking	_____	_____	_____
Language development	_____	_____	_____
Toilet training	_____	_____	_____

Overall development _____ _____ _____

21) As a child, did you have any of these conditions? (Check all that apply.)

_____ Attention problems	_____ Head injury	_____ Muscle tightness or weakness
_____ Clumsiness	_____ Hearing problems	_____ Speech problems
_____ Developmental delay	_____ Hyperactivity	_____ Vision problems
_____ Frequent ear infections	_____ Learning disability	_____ Psychological / behavior problems
_____ Problems socializing	_____ Drug use	_____ Involvement with police or juvenile Authorities

Other problems:_____

MEDICAL HISTORY

CHILDHOOD MEDICAL HISTORY

22) Check all the conditions that were diagnosed when you were a child. Add any helpful details (age at diagnosis, treatment provided, etc.)

_____ Allergies	_____ Epilepsy or seizures	_____ Pneumonia
_____ Asthma	_____ Fevers (104 F or higher)	_____ Poisoning
_____ Brain infection or disease	_____ Heart problems	_____ Polio
_____ Cancer	_____ Immune system disease	_____ Rheumatic fever
_____ Cerebral palsy	_____ Kidney problems	_____ Scarlet fever
_____ Chicken pox	_____ Lung (respiratory) disease	_____ Tuberculosis
_____ Colds (excessive)	_____ Measles	_____ Venereal disease
_____ Diabetes	_____ Meningitis	_____ Whooping cough
_____ Encephalitis	_____ Oxygen deprivation	_____ Psychological

_____ Other diseases or disabilities:_____

_____

23) As a child, were you exposed to excessive amounts of lead (e.g., eating paint chips, living next to high Concentration of automobile exhaust fumes, etc.)? _____ Yes _____ No

If yes, explain:_____

24) As a child, did you have an accident which required a hospital visit? _____ Yes _____ No

If yes, describe what happened:_____

25) Did you ever suffer a serious injury to your head? _____ Yes _____ No

If yes, explain the circumstances and any problems you had afterward: _____

_____

_____

26) How would you describe your nutrition as a child and adolescent?

Excellent _____ Average _____ Poor_____

27) List the medications that were regularly given to you as a child:

Medication	Reason for medication
a) _____	_____
b) _____	_____
c) _____	_____
d) _____	_____

ADULT MEDICAL HISTORY

28) Check all that currently apply:

_____ AIDS, ARC, or HIV+	_____ Heart disease	_____ Parkinson disease
_____ Allergies	_____ Huntington disease	_____ Polio
_____ Arteriosclerosis (artery disease)	_____ Hypertension	_____ Psychiatric problems
_____ Arthritis	_____ Kidney disease	_____ Radiation exposure/ Therapy
_____ Blood disorder	_____ Liver disease	_____ Senility (Dementia)
_____ Brain disease/infection	_____ Lung disease	_____ Stoke or TIA
_____ Cancer or chemotherapy	_____ Malnutrition	_____ Thyroid disease
_____ Diabetes	_____ Meningitis	_____ Venereal disease
_____ Hazardous substance exposure	_____ Multiple sclerosis	_____ Arrest or incarceration

_____ Any other problems:_____

_____

29) Have you ever been placed on disability? _____ Yes _____ No

If yes, please explain:_____

30) List any medication you currently take (over-the-counter or prescription medication) and the dosage.

Medication	Dosage	Usage
a) _____		
b) _____		
c) _____		
d) _____		
e) _____		

31) Do you have epilepsy or a seizure disorder? _____ Yes _____ No

If yes, check the one you have been diagnosed with:

PARTIAL	GENERALIZED	_____ UNCLASSIFIED TYPE
_____ Simple partial (Jacksonian)	_____ Absence (Petit mal)	

_____ Complex partial (Psychomotor)
_____ Partial evolving into generalized

_____ Myoclonic
_____ Clonic
_____ Tonic
_____ Tonio-clonic (Grand mal)
_____ Atonic

_____ I HAVE A SEIZURE DISORDER BUT DO NOT KNOW WHICH TYPE.
Please describe it:_____

32) Describe all of the hospitalizations you have had:
a) _____
b) _____
c) _____
d) _____

FAMILY HISTORY

The following questions deal with your biological mother, father, brothers, and sisters.

MOTHER

33) What is your mother's name? Include maiden name)_____
34) Is she alive? Yes_____ No_____ If deceased, what was the cause of death?_____
35) Mother's occupation: _____
36) Mother's level of education: _____
37) Mother's hobbies: _____
38) Does your mother have a known or suspected learning disability? Yes_____ No_____
If yes, describe: _____
39) Does your mother have a known or suspected psychological disorder? Yes_____ No_____
If yes, describe: _____
40) Briefly describe your mother's health history:_____
_____

FATHER

41) What is your father's name?_____
42) Is he alive? Yes_____ No_____ If deceased, what was the cause of death?_____
43) Father's occupation: _____
44) Father's level of education: _____
45) Father's hobbies: _____

46) Does your father have a known or suspected learning disability? Yes_____ No_____
If yes, describe: _____
47) Does your father have a known or suspected psychological disorder? Yes_____ No_____
If yes, describe: _____
48) Briefly describe your father's health history:_____

_____

49) When you were born what was your mother's age? _____ Father's age_____

50) How many brothers and sisters do you have? _____

Names and ages: _____

_____

51) Where are you in the birth order? _____

52) Are there any problems (physical, academic or psychological) associated with any of your brothers or sisters?

Yes_____ No_____

If yes, describe:_____

_____

_____

53) Who raised you?

_____ Biological parent(s) _____ Relatives _____ Foster parents

_____ Biological parent plus other person _____ Adoptive parents

_____ Institutional setting _____ Other

Who? _____

54) What languages were spoken at home when you were a child?

1) _____ 2) _____

Primary language Secondary language

55) Please check all that exist(ed) in close biological (blood) family members (parents, brothers, sisters, grandparents, aunts, uncles). Note who it was and describe the problem where indicated.

Who?

_____ Epilepsy or seizures _____

_____ Learning disability _____

_____ Left-handedness _____

_____ Mental retardation _____

Neurological (brain) disease

_____ Alzheimer's disease or senility _____

_____ Huntington disease _____

_____ Multiple sclerosis _____

_____ Parkinson disease _____

_____ Other neurological disease (describe) _____

Psychiatric illness

_____ Alcoholism _____

_____ Bipolar illness (manic-depression) _____

_____ Depression _____

_____ Personality disorder _____

_____ Schizophrenia _____

_____ Other psychiatric illness (describe) _____

_____ Speech or language disorder _____

_____ Other major disease or disorder (describe) _____

PERSONAL HISTORY

MARITAL HISTORY

56) Current marital status: Married_____ Divorced_____ Widowed_____ Separated_____

57) Years married to current spouse: _____

58) Number of times married: _____

59) Spouse's name: _____ Spouse's age:_____

60) Spouse's occupation: _____

61) Spouse's education: _____

62) Spouse's health: Excellent_____ Good_____ Poor_____

If problems, please describe: _____

_____

63) Not married, but living with someone: Yes_____ No_____ His/her age:_____

His/her health: Excellent_____ Good_____ Poor_____

If problems, please describe:_____

_____

His/her occupation:_____

Partner's education:_____

64) Do you have any children: Yes_____ No_____ His/her ages:_____

65) Do your children have learning disabilities or other systemic diseases? Yes_____ No_____

If yes, please explain:_____

_____

_____

EDUCATIONAL HISTORY

66) Highest grade or degree earned:_____

67) How would you describe your usual performance as a student in (please circle highest level):

High school College

Name of School	City/State	# Yrs Completed	Date Finished	Grade Average	Diploma Degree

				(A,B,C,D)	
Grades 1-6	_____	_____	_____	_____	
7-8/9	_____	_____	_____	_____	
9/10-12	_____	_____	_____	_____	_____
University	_____	_____	_____	_____	_____
Post-graduate	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

Please provide any additional helpful comments about your academic performance: _____

_____

68) What was your best subject(s)? _____ Weakest subject(s)_____

69) Were you ever held back to repeat a grade? Yes_____ No_____

If yes, what grade(s):_____ Reason:_____

70) Were you ever in any special class(es) or received special services? Yes_____ No_____

If yes, what grade? _____ or age?_____ What type of class?_____

_____

OCCUPATIONAL HISTORY

71) Current job title:_____

72) Salary: Under $10,000_____ $10,000-$29,999_____ $30,000-$50,000_____ $50,000-$70,000_____

Over $70,000_____

73) How long have you been on this job? _____

74) Current job responsibilities:_____

_____

_____

(Start with most recent)		Reason for leaving	Time on this job
75) Prior jobs:	a)_____	_____	_____
	b)_____	_____	_____
	c)_____	_____	_____
	d)_____	_____	_____

76) At any time on a job, were you exposed to toxic, hazardous, noxious or otherwise dangerous or unusual substances (e.g., lead, mercury, radiation, solvents, pesticides, chemicals, etc)? Yes_____ No_____

MILITARY HISTORY

77) Branch:_____

78) Discharge rank: _____ Type of discharge:_____

79) Major military duties:_____

80) Did you sustain any physical injuries in the military? Yes_____ No_____

If yes, describe:_____

81) Were you ever exposed to any dangerous or unusual substances during your service (e.g., Agent Orange, radiation, etc? Yes_____ No_____

If yes, explain:_____

RECREATION/SOCIALIZATION

82) Briefly list the types of recreation activities (sports, games, TV, hobbies, etc.) you engaged in prior to your Injury or illness? _____

_____

_____

83) Briefly list the types of recreation activities that you presently engage in: _____

_____

_____

84) Briefly list typical social activities you engaged in (Church, clubs, service organizations, etc.) before your Injury or illness: _____

_____

_____

85) Briefly list typical social activities you engage in:_____

_____

_____

SUBSTANCE USE HISTORY

ALCOHOL

86) I started drinking regularly at age:

Less than 10 years old _____ 10-15_____ 16-18_____ 19-21_____ over 21_____

87) I drink alcohol: rarely or never_____ 1-2 days/week_____ 3-5 days/week_____ Daily_____

I used to drink but have stopped_____ Date stopped_____

88) Preferred type(s) of drinks:_____

89) Usual number of drinks I have at a time: _____

90) My last drink was: Less than 24 hours ago_____ 24-48 hours ago_____ over 48 hours ago____

91) Check all that apply:

_____ I can drink more than most people my age and size before I get drunk.

_____ I sometimes get into trouble (fights, legal difficulty, problems at work, conflicts with family, accidents, etc.) after drinking

_____ I sometimes black out after drinking

DRUGS

92) Please check all the drugs you are now using or have used in the past:

	Presently using	Used in the past
_____ Amphetamines (inc. diet pills)	_____	_____
_____ Barbiturates (downers, etc.)	_____	_____
_____ Cocaine or crack	_____	_____
_____ Hallucinogenics (LSD, acid, STP, etc.)	_____	_____
_____ Inhalants (glue, nitrous oxide, ect.)	_____	_____
_____ Marijuana	_____	_____
_____ Opiate narcotics (heroin, morphine, etc.)	_____	_____
_____ PCP (or angel dust)	_____	_____

Please list all other drugs: _____

_____

(93) Do you consider yourself dependent on any above drug? Yes_____ No_____

Which one(s)? _____

_____

94) Do you consider yourself dependent on any prescription drug? Yes_____ No_____

Which one(s)?_____

_____

95) Check all that apply:

_____ I have gone through drug withdrawal

_____ I have used I.V. drugs _____ I have been in drug treatment

96) Have you ever been arrested for, or convicted of, any offense? Yes_____ No_____

If so, please explain:_____

_____

MEDICAL

97) Identify the physician who is most familiar with your recent problems:

Name of physician:_____

Address:_____

_____

Phone: _____

Date of your last medical check-up:_____

Findings of the check-up:_____

_____

_____

98) Have you had a prior psychiatric, psychological or neuropsychological evaluation? Yes_____ No_____

If yes, complete this information:

Name of Doctor:_____

Address:_____

_____

Phone: _____

Date of and reason for this evaluation_____

_____

Findings of the evaluation:_____

_____

_____

99) Is there any other information that you believe would be relevant to this evaluation? _____

_____

_____

_____

_____

_____

_____

_____

100) What do you believe is your biggest problem? _____

_____

_____

_____

_____

_____

101) Are you presently involved in a lawsuit? Yes_____ No_____

If so, what?_____

_____

Attorney's Name: _____

Address:_____

Phone number:_____

How many lawsuits have you filed in your life? _____

102) Do you presently operate a vehicle? Yes_____ No_____

Do you have a current license? Yes_____ No_____ State:_____

License Number:_____ Type_____ Restrictions?_____

MEDICAL HISTORY

Patient's Name: _____ Date_____

Have you suffered from any serious childhood illness: Yes_____ No_____

If yes, which ones? _____

Do you currently have or have had a history of any of the following conditions? (Circle all that apply)

Allergies
Arthritis
Asthma
Broken Bones
Bronchitis
Cardiovascular Disease
Cancer
Chronic Pain
Colitis
Concussion
Congenital Abnormality
Diabetes
Emphysema
Gall Stones
Head Trauma
Heart Attack
Hemorrhoids
Herpes
High Blood Pressure
Irritable Bowel Syndrome
Kidney Disease
Liver Disease
Lupus
Mental Illness
Pulmonary Disease
Seizures
Stroke
Thyroid Disease
Tuberculosis
Ulcers
Other_____
Other_____
Other_____

Is there any family (blood relative) history of serious disease? Yes_____ No_____
If so, which ones?_____

Have you had any operations/surgical procedures? Yes_____ No_____
If so, please list procedure(s) and year(s):_____

Do you currently have or have you had a history of any of the following symptoms? (Circle all that apply)

Headaches	Dizziness	Loss of Balance
Blackouts	Fainting	Blurry Vision
Poor Vision	Poor Hearing	Noise in Ears
Congested Nose	Shortness of Breath	Sinus Problems
Sore Throat	Coughing	Rapid Heartbeat
Irregular Heartbeat	Heartburn	Burping
Nausea	Vomiting	Gas
Bloated Stomach	Constipation	Diarrhea
Urination Problems	Weakness	Menstruation Problems
Twitching	Trembling	Cramps
Numbness	Skin Problems	Hyperventilation
Sleep Problems	Poor Appetite	Overeat
Weight Loss	Weight Gain	Low Sex Energy

Sexual Performance Problems Other:_____

Do you have any pains? Yes_____ No_____

If so, what body part?_____

List any prescription medications you take:_____

_____

Do you use drugs? Yes_____ No_____ If so, which ones?_____

Do you drink alcohol? Yes____ No_____ If so, how many times per month?_____

On an average, how many drinks do you consume when you have alcohol?_____

Do you smoke tobacco? Yes_____ No_____ If so, how much per day?_____

Have you ever had any mental health treatment? Yes_____ No_____

If yes, when treated and for what condition?_____

Is there any family (blood relative) history of mental illness? Yes_____ No_____

If so, which condition(s)?_____