Child Neuropsychology & Counseling Center, P.C.

Child and Family History

Date: _____ **Referred by:** _____

Child's Name: _____ **Date of Birth:** _____ **Age:** _____

Social Security #:_____ **Gender:** Male Female Other **Race:** _____

Street Address: _____**City:**_____ **State:** _____ **Zip Code:** _____

Home Phone #:_____ **Work #:**_____**Cell #**_____**E-mail**_____

School: _____ **Grade:** _____ **Is child in Special Education?** Yes no

Parent/Guardian's Name: _____ **Age:** _____ **Education:** _____

Place/Type of Employment: _____

Parent/Guardian's Name: _____ **Age:** _____ **Education:** _____

Place/Type of Employment:_____

Are the parents (circle which) - ***Married*** ***Separated*** ***Divorced*** ***Never Married to One Another***

If divorced – Please list year – and how often your child sees each parent-

Is there another legal guardian besides the parent(s)? Yes no **If yes, please state name, address, phone number, and relationship to child (e.g., foster parent, grandparent, etc.):**_____
_____

Is the child adopted? Yes no **If yes, age when adopted:** _____

Please list all other adults and children living in the home:

Name	*Age*	*Relationship to this child*	*Medical Educational or Emotional Problems*

Name of person completing this form: _____ **Relation to child:** _____

What is your primary concern regarding your child?

Describe the problem(s) your child is having AND when (year) the problem(s) began:

What issues, situations, or other problems have contributed to this difficulty?

What information/help do you hope to gain from this evaluation? What questions would you like answered?

DEVELOPMENTAL and MEDICAL HISTORY

PREGNANCY AND DELIVERY

Length of pregnancy (e.g., full term, 40 weeks, 32 weeks, etc,):_____ Length of delivery (in hours):_____

Mother's age when child was born: _____ Child's birth weight: _____ Was pregnancy planned? Yes No

Please *circle* any of the following that occurred during pregnancy or delivery:

Unusual bleeding	Excessive weight gain (more than 30 lbs.)	Toxemia/preeclampsia
Rh factor incompatibility	Frequent nausea or vomiting	Serious illness or injury
Took illegal drugs	Used alcoholic beverages (amount_____)	Smoked cigarettes
Took prescription drugs (name of medications: _____)		
Medication to ease labor pains	Forceps used during delivery	Induced delivery
Breech delivery	Cesarean section	Other problems_____

Please *circle* any of the following conditions if they affected your child during delivery or within the first few days after birth:

Injured during delivery	Heart or lung distress during delivery	Delivered with cord around neck
Needed oxygen	Trouble breathing following delivery	Was cyanotic, turned blue
Was jaundiced, turned yellow	Had an infection	Had seizures
Was given medications	Born with a congenital defect	Was in hospital more than 7 days

If your child was hospitalized after birth please specify WHY and HOW many days/weeks/months:_____

Infant Health and Temperament:

Please *circle* any of the following if they describe your child's behavior during his/her first 12 months:

Difficult to feed	Difficult to get to sleep	Colicky
Difficult to put on a schedule	Cheerful	Alert
Affectionate	Sociable	Easy to comfort
Difficult to keep busy	Overactive, in constant motion	Very stubborn, challenging

EARLY DEVELOPMENTAL MILESTONES:

At what age did your child first accomplish the following: If unsure, please provide your best guess

Smiled _____ **Sat without help _____** **Crawled _____** **Stood _____**

Fed self _____ **Walked alone _____** **Said first word _____** **Said phrases _____**

Bowel trained, day and night _____ **Bladder trained, day and night _____** **Dressed self _____**

How do you feel your child developed? ____ Faster than average ____ Average ____ Slower than average

HEALTH HISTORY

Child's Pediatrician / Family Doctor: _____ Date of last physical exam:_____

At any time has your child had the following:

	Never	Past	Present
Asthma	O	O	O
Allergies	O	O	O
Diabetes, Arthritis or other chronic illnesses	O	O	O
Epilepsy or seizure disorder	O	O	O
Febrile seizures	O	O	O
Chicken pox or other common childhood illness	O	O	O
Heart or blood pressure problems	O	O	O
High fevers (over 103º)	O	O	O
Broken bones	O	O	O
Severe cuts requiring stitches	O	O	O
Head injury with loss of consciousness	O	O	O
Lead poisoning	O	O	O
Surgery	O	O	O
Lengthy hospitalization	O	O	O
Speech or language problems	O	O	O
Chronic ear infections	O	O	O
Hearing difficulties	O	O	O
Eye or vision problems	O	O	O
Fine motor / handwriting problems	O	O	O
Gross motor difficulties, clumsiness	O	O	O

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Appetite problems (overeating OR under eating *circle*)	○	○	○
Sleep problems (falling asleep, staying asleep *circle*)	○	○	○
Soiling problems	○	○	○
Wetting problems	○	○	○

***If "yes" on wetting and/or soiling problems- Please indicate year this ended and/or are ongoing**

***If "yes" on broken bones- Please indicate what side of the body (Left/Right)? What year this occurred? What happened? Was treatment required (cast, boot etc) If yes, for how long?**

Other health difficulties:

Diagnosis Location Date of Diagnosis Diagnosing Physician

What was the date of you child's last vision exam? _____ Results?_____

Has your child ever had tubes in their ears? Yes No. If Yes, Date(s) _____Age(s)_____

Doctor's name_____

Has your child ever been examined by an audiologist? Yes No If Yes, When? _____Results? _____

Please list prior surgeries.

Type of Surgery DATE Doctor's NAME /Location (State and name of hospital)

Any falls, concussions, migraines, bumps to the head etc.? _____

If yes- Please indicate year, what happened, and if loss of consciousness occurred (how many seconds/minutes)

Has your child received Chemotherapy? YES NO If YES complete the following.

Dates of Treatment (inclusive) Number of rounds Type of chemotherapy Side effects?

Date of last treatment: _____ Are more scheduled at this time?_____

Has your child received Radiation or Gamma Knife treatments? YES NO If Yes complete the following:

Type of Treatment (i.e. radiation/gamma knife) Dates of Treatment (inclusive) Side Effects?

Date of last treatment?_____ Are more scheduled at this time? _____

List both prescription and over-the-counter medications your child is presently using for any physical conditions:

Medicine	**Dosage**	**Reason for taking**
(Vitamins and melatonin count)		

Your child's overall general health is ____ Excellent ____ Good ____ Fair ____ Poor
Your child's physical abilities compared to other children his/her age: (*Please Circle)*
Below Average Average Above Average
Has your child ever had physical/occupational therapy?

When (year began and ended) ? Where (location)? How Often?

Your child's speech/language abilities compared to other children his/her age: (*Please circle)*
Below Average Average Above Average

Has your child ever had Speech Therapy?

When (year began and ended)? Where (location)? How Often?

Have there ever been any concerns about his/her development?

FAMILY

Is there a pattern of physical illness in your family which keeps repeating (e.g., heart disease, cancer, seizures, etc.)? If so, what?

Has your child or any other person in your family/extended family, including your self, experienced any of the following problems?

Concern	**Person(s) who experienced this/relationship to patient**
Anxiety	
Depression	
Bipolar Disorder	
Epilepsy	
Suicide	
Stuttering	
Explosive Temper	
Mental Retardation	
Learning Disabilities	
ADHD	
Schizophrenia	

Alcohol abuse _____
Drug abuse _____
Emotional Problems _____
Other: _____ _____

EDUCATION

List all schools your child has attended in order:

Full Name of school_____Location (city/state)____School District_____Grades Attended (all)_____

Has your child ever received services through Early Childhood Intervention (ECI) or Pre-School Program for Children with Disabilities (PPCD)? Yes No If yes, please state what agency they received these services through and the ages during which your child received these services._____

Does he/she have any learning problems in school? Y N **If yes, what are the problems?**

At what age and grade were these problems first noticed?_____

What actions were taken at that time? _____

Has he/she ever had psychological or educational testing for learning or behavior issues at school? Yes no
If yes, for what issues? _____
When was date of last testing?_____**Results?**_____

Is child receiving services under Section 504 or Special Education? Yes No If Yes, please describe all services they are currently receiving and those received in the past_____

Have these services been helpful to your child? Yes No

Has he/she ever repeated or skipped a grade? Yes No **If yes, which one(s)?**_____

How has his/her attendance been? _____What types of grades? _____Have the grades changed a lot? _____

Does he/she have any behavior or discipline problems at school? Yes No **If yes, what problems? _____**

What types of extracurricular school activities does your child participate in (e.g., clubs, band, drama, etc.)?_____

Is there any family history of learning or school behavior problems in the family? Yes No **If yes, what were/are the problems and what is the individual's relationship to patient?**

_____
_____

SOCIAL HISTORY

What are your child's major strengths? _____
_____

What are your child's major weaknesses? _____
_____

How many close friends does your child have? None 1 2 3 4 or more

Does your child have other friends besides those you would classify as "close" friends? Yes No

What is the age range of his/her friends? _____ **Are most of the friends** older, younger **or** same age **(circle which)?**

How does your child get along with his/her friends? _____

Has there been a change in his/her circle of friends lately? Yes No **If yes, what has been the change?** _____
_____

Do his/her friends tend to get into trouble? Yes No

What losses, changes, crises, and transitions do you believe have significantly impacted your child's life (e.g., divorce, arrests, graduation, moves, death in family, etc.)?_____
_____
_____

Is there anything else about your child's lifestyle, including the family, that would be helpful for me to know?
_____
_____

PSYCHOLOGICAL TREATMENT HISTORY

Has your child ever been in counseling before? Yes No **If so, with whom?** _____

What was the primary problem for which he/she was in counseling? _____
_____

When was the counseling? (what year did these begin and end) _____

For how long? _____ **What was the outcome?** _____
_____

Has your child ever been hospitalized for emotional problems and/or alcohol/drug treatment? Yes No
If so, when _____, **where** _____, **outcome** _____
_____

What medications has your child taken in the past for emotional problems? _____

What medications is your child currently taking for emotional problems? _____

Who is prescribing these medications? _____

Has your child ever completed psychological testing? Yes no **If so, with whom? _____**
When? _____ What was the diagnosis or recommendations? _____
_____

BEHAVIORAL and EMOTIONAL CONCERNS

Please check any of the following if your child used to exhibit and/or presently exhibits any of these problems:
(Do not check if your child never exhibited the problem. "Now" means within the last 3-6 months)

	Past	Now
Thoughts of hurting self	____	____
Thoughts of committing suicide	____	____
Plans to commit suicide	____	____
Attempts to commit suicide	____	____
Threats to commit suicide	____	____
Actually harmed someone	____	____
Thoughts of harming someone	____	____
Plans to harm someone	____	____
Attempts to harm someone	____	____
Threats to harm someone	____	____
Depressed or irritable mood most of the day for at least 2 weeks	____	____
Markedly lower interest or enjoyment in almost all activities	____	____
Significant weight loss, when not dieting	____	____
Significant weight gain	____	____
Decreased or increased appetite nearly every day	____	____
Insomnia at night or excessive sleep during the day, nearly every day	____	____
Agitated or excessive movement nearly every day	____	____
Lethargic, sluggish, slow moving nearly every day	____	____
Fatigue and loss of energy nearly every day	____	____
Feelings of worthlessness or excessive, inappropriate guilt nearly every day	____	____
Diminished ability to think or concentrate nearly every day	____	____
Recurrent thoughts of death	____	____
Recurrent thoughts of suicide	____	____
Was very depressed every day for at least two weeks	____	____
Was somewhat depressed or irritable more days than not over past 12 months	____	____

	Past	Now
Mood was unusually giddy, joyous or ecstatic for at least 1 week	____	____
Mood was persistently expansive (felt super-human or able) for at least 1 week	____	____
Mood was abnormally and persistently irritable for at least 1 week	____	____
***During the week or more he/she showed one of the above 3 moods did he/she*:**		
Have inflated self-esteem or felt grandiose about self	____	____
Show decreased need for sleep	____	____
Was more talkative than usual and seemed pressured to keep talking	____	____
Skip from one idea to another as if his/her ideas were flying rapidly by	____	____
State that his/her thoughts seemed to be racing	____	____

Become unusually persistent in accomplishing tasks	____	____
Seem very agitated, overly active, or abnormally restless	____	____
Showed excessive involvement in pleasurable but potentially harmful activities	____	____
Excessive anxiety and worry about a number of event or activities	____	____
Anxiety on most days for at least 6 months	____	____
Restless and feels on edge	____	____
Easily fatigued or tired	____	____
Difficulty concentrating or mind going blank	____	____
Irritability	____	____
Muscle tension	____	____
Difficulty falling asleep, staying asleep, or restless sleep	____	____
Unreasonable fear in social settings where others may notice or scrutinize him/her	____	____
Strong fear of being humiliated or embarrassed in front of others	____	____
Unreasonable, excessive fear of an object or situation (e.g., animal, heights, etc.)	____	____
Recurrent, excessive distress when separated from home or parent	____	____
Persistent worry that parent will leave, or he/she will lose parent	____	____
Nightmares	____	____
Repeated complaints of headaches, stomachaches, nausea or vomiting	____	____
Repeated concerns about having a physical disorder or disease	____	____
Compulsively checks, counts, puts in order, or cleans, often in rigid fashion	____	____
Hears voices or sees things that are not really there	____	____
Believes that others are trying to harm him	____	____
Believes that others are controlling his mind	____	____
Is extremely suspicious of others	____	____
Others view his behavior and manner of speaking as odd or "crazy"	____	____
Often loses temper	____	____
Often argues with adults	____	____
Often actively defies or refuses adults' requests or rules	____	____
Often deliberately annoys people	____	____
Often blames other for his/her mistakes or misbehavior	____	____
Is often touchy or easily annoyed by others	____	____
Is often angry or resentful	____	____
Is often spiteful or vindictive	____	____
Often bullies, threatens, or intimidates others	____	____
Often initiates physical fights		
Has used a weapon that can cause serious physical harm (e.g., gun, bat, brick, etc.)	____	____
Has been physically cruel to people	____	____
Has been physically cruel to animals	____	____
Has stolen while confronting a victim (e.g., mugging, purse snatching, etc.)	____	____
Has forced someone into sexual activity	____	____
	Past	**Now**
Has deliberately engaged in fire setting with intention of causing damage	____	____
Has deliberately destroyed others property (other than by fire setting)	____	____
Has broken into someone else's house, building, or car	____	____
Often lies or "cons" to obtain goods or favors and avoid obligation	____	____
Has stolen items without confronting a victim (e.g., shoplifting, forgery, etc.)	____	____
Often stays out at night despite parental prohibitions	____	____
Has run away from home, foster care, group home overnight	____	____
Is often truant from school	____	____

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Often fails to give close attention to details or makes careless mistakes	____	____
Often has difficulty sustaining attention in tasks or play activities	____	____
Often does not seem to listen when spoken to directly	____	____
Often does not follow through on instructions and fails to finish work	____	____
Often has difficulty organizing tasks and activities	____	____
Often avoids, dislikes or is reluctant to engage in tasks requiring sustained effort	____	____
Often loses things necessary for tasks or activities (e.g., books, tools, pencils, etc.)	____	____
Is easily distracted by extraneous stimuli	____	____
Is often forgetful in daily activities	____	____
Often fidgets or squirms in seat	____	____
Often leaves seat in class or other situations where remaining seated is expected	____	____
Often runs or climbs excessively or feel restless and wants to move about	____	____
Often has difficulty playing quietly	____	____
Often talks excessively	____	____
Often blurts out answers before the other person has finished talking	____	____
Often interrupts or intrudes on others	____	____
Often has difficulty awaiting his/her turn	____	____