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Initial History Form – Children and Adolescents

General Information

Child's Name:____ Today's Date: __________________

Child's Date of Birth: ________________ Child's Age: _________ ☐ Male ☐ Female

Person completing form: _________________________________ Relationship to child: ________________________

Complete home address: ____

Home phone: ________________ Work phone: __________________Cell phone/other: _______________________

Child's primary physician, address, and phone: ____

Child's neurologist and/or neurosurgeon:____

Referral Information

Who referred you for neuropsychological evaluation? ____

What are you hoping to gain from these services? ____

____

What do you think is the major cause of this child's difficulties? ____

____

Describe some of this child's strengths: ____

Describe some of this child's weaknesses: ____

Pregnancy and Birth History

Child is: ☐ biological ☐ adopted (at age _______________) ☐ foster (at age _______________)

Were you (or the biological mother if adopted/foster) under a doctor's care? ☐ No ☐ Yes

Number of previous: pregnancies _______ miscarriages _______

Circle any of the following health complications that occurred during the pregnancy and provide detail if able.

Fertility problems	Vaginal bleeding	Toxemia	High blood pressure
Gestational diabetes	Trauma	Fever/rash (e.g., flu, measles)	Emotional problems
Abnormal weight gain	Anemia	Excessive swelling	Excessive vomiting
Blood incompatibility	Smoking	Alcohol	Illicit drugs
Medications	Hospitalization(s)	X-ray/imaging ______________	Other: _____________

Medications, tobacco, alcohol, or other drugs during pregnancy:____

Age of mother at delivery: _______ Age of father at delivery: _______ Age of mother at birth of first child: ______

Birth weight: _______ lbs. _______ oz. Length of pregnancy: _______ weeks Length of labor: _______ hours

Apgar scores: ______________ Delivery was: ☐ vaginal ☐ Cesarean (reason: ___________________________)

Circle any of these complications that occurred during delivery/birth and provide detail if able.

Breech position	Cord around neck	Meconium staining	Lacking oxygen/hypoxic	Forceps used
Labor induced	Abnormal color____________	Phototherapy____________	Other:_______________________	

Did baby breathe spontaneously? ☐ No ☐ Yes

Oxygen required? ☐ No ☐ Yes If yes, for how long? ____

Transfusion required? ☐ No ☐ Yes If yes, why and how many? ____

Length of stay in hospital: Mother: _______ days Child: _______ days

Medical problems after hospital discharge (e.g., jaundice, apnea, surgery)____

Any problems in first few months? ☐ No ☐ Yes Explain: ____

Did mother experience postpartum (after birth) depression? ☐ No ☐ Yes ____________________________________

Describe this child's temperament as an infant: ____

Developmental History

Motor

Age sat alone: _________ crawled: _________ stood alone: _________ walked alone: _________

Slow to develop motor skills or awkward compared to siblings/friends?____

Handedness: ☐ right ☐ left ☐ Ambidextrous/both Age established hand dominance _____________________

☐ History of physical therapy? Dates & reason____

☐ History of occupational therapy? Dates & reason____

Speech/Language

Age spoke first word: _________ expressed 2-3 word phrases: ___________ spoke in structured sentences: __________

☐ Oral-motor problems (e.g., late drooling, poor sucking, poor chewing)? ______________________________________

☐ Speech delay/problems (e.g., stutters, difficult to understand)?____

☐ History of speech/language therapy? Dates & reason____

☐ Other language spoken in home (besides English)? ____

Toileting

Age trained for bladder________ Age trained for bowels_________ Bed wetting?____ If yes, until age=______________

☐ Urine accidents during the day? Until age=_______ When/where did this occur? ______________________________

☐ Soiling accidents? Until age=_______ When/where did this occur?____

☐ Current wetting or soiling problems? Explain: ____

Medical History

Circle any of the following that apply. Indicate age of onset and duration.

Failure to thrive	Febrile seizures	Diagnosed epilepsy	Staring spells	Lead poisoning
Toxic ingestion	Meningitis	Encephalitis	Asthma	Allergies
Diabetes	Loss of consciousness	Stomach pain	Vomiting	Headaches
Constipation	Urination problems	Accident prone	Frequent ear infections	Sleep problems
Eating problems	Tics/twitching	Repetitive movements	Impulsivity	Temper tantrums
Nail biting	Clumsiness	Head banging	Self-injurious behavior	Rocking back and forth

Has vision been checked? ☐ No ☐ Yes Any problems? ____

Has hearing been checked? ☐ No ☐ Yes Any problems? ____

History of ear tubes? ☐ No ☐ Yes If yes, when and how many sets? ____

Current medications and reasons: ____

____

List any head injuries, concussions, serious illnesses, surgeries (etc.) **and age of occurrence**: ________________________

____

If any of the following have been performed, list dates and results.

CT of brain/head ____

brain/stem MRI ____

EEG____

MRA of head____

SPECT or PET____

MEG____

Any other non-routine exams involving the brain/nervous system________________________

Family History: Please describe any family history of the following problems. Indicate the relationship(s) to the child.
Learning disabilities, ADD/ADHD____

Psychiatric/neurochemical (e.g., depression, anxiety, schizophrenia, bipolar) ____________________

Alcoholism or substance abuse____

Autism ____

Intellectual disability/delay____

Neurological (e.g., Alzheimer's, Parkinson's, TBI, epilepsy)____________________________

Other (e.g., cancer, diabetes, migraines, cardiovascular/heart disease)________________________

Anyone else in family have problems similar to this child's reason for referral? ____________________

Family Information
Mother's name: ____________________________Age: _____Education: ____________

Occupation: ________________________Employer: ________________________

Father's name: ____________________________Age: _____Education: ____________

Occupation: ________________________Employer: ________________________

Parents are: ☐ married ☐ separated ☐ divorced ☐ never married ☐ Other________________

Describe current relationship between parents (e.g., loving, friendly, civil, volatile)________________

Do parents generally agree on discipline/child rearing strategies? ☐ No ☐ Yes If no, explain____________

If divorced, list custody and visitation arrangements________________________________

List all siblings, step-parents, grandparents (etc.) in the household(s).

Age	Sex	Name/relationship to this child	Living at home?	Problems?
______	______	________________________	____________	________________
______	______	________________________	____________	________________
______	______	________________________	____________	________________
______	______	________________________	____________	________________
______	______	________________________	____________	________________
______	______	________________________	____________	________________

Is this child in a child-care setting besides school? ☐ No ☐ Yes How many hours/days? ________________

Has this child experienced death of loved one or separation from loved one? ☐ No ☐ Yes If yes, explain:__________

____

Social History and Adaptive Functioning

Does this child:

have difficulty relating to or playing with other children?	☐ No	☐ Yes
interact better with adults than children his/her own age?	☐ No	☐ Yes
have difficulty making/keeping friends?	☐ No	☐ Yes
understand social gestures?	☐ No	☐ Yes
have a good sense of humor?	☐ No	☐ Yes
understand social cues well (e.g., knows when others are angry)?	☐ No	☐ Yes
have problems with peer pressure (e.g., alcohol or drug use)?	☐ No	☐ Yes
show a desire to please you?	☐ No	☐ Yes
manage change in routine/expectation well?	☐ No	☐ Yes
require excessive prompting to complete chores/responsibilities?	☐ No	☐ Yes

When did you first become concerned about his/her social, emotional, behavioral functioning?______________________

Psychological History

List any previous direct contact with any social agency, psychologist, or psychiatrist.

Name and type of professional	Reason for services	Date(s)
______________________________	____	_________________
______________________________	____	_________________
______________________________	____	_________________

Describe this child's typical mood: ____

Academic History

Current school: ____ Current grade: ______________

Classroom placement: ☐ regular ☐ resource/special education ☐ other____

Has this child been tested for gifted or special education? ☐ No ☐ Yes Results: __________________________________

Does this child have a 504 Plan or an IEP? ☐ No ☐ Yes Describe: ____

Any grades that were skipped or repeated? ☐ No ☐ Yes Explain: ____

Circle any of the following for which teachers have reported problems.

Reading Spelling Math Writing Attention/concentration Behavior/emotion Social adjustment

Describe any academic problems that occurred in:

Preschool ____

Kindergarten ____

Early elementary school (1st to 2nd) ____

Upper elementary school (3rd to 5th) ____

Middle school (6th to 8th) ____

High school ____

Additional Comments:____

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