NEUROPSYCHOLOGICAL CHILD HISTORY

INSTRUCTIONS TO PARENT OR GUARDIAN: This form must be completed and returned to Meier Clinics before your child's appointment. Please fill out the form to the best of your knowledge. If some questions do not apply to your child, write in NA. IF you need more space or wish to make additional comments, please do so on a separate sheet of paper and attach it to this form. Thank you.

Child's Name: ____ Date of Birth: ________________________

Home Address: ____

Telephone: (_________)______________________

Mother's Name: _____________________________ Father's Name: _________________________________

Business Name & Address of ❑Mother or ❑Father: ____

____

Business Phone: (__________)__________________

Pediatrician: _________________________________ Phone #: (_______) __________________________

Address: ____

Neurologist: ________________________________ Phone #: (_______) __________________________

Address: ____

School currently attending: ____ Grade: ______________

Address: ____

Phone #: (_________)_____________________

Reason for consultation: ____

____

____

____

Referred by: ____

Name of person filling out this form: ____

Relationship to the child: ____ Date: _____________________

PREGNANCIES

Was the child adopted? ❑ yes ❑no

Indicate the month(s) of your pregnancy that you experienced any of the following complaints:

Anemia _______________ High blood pressure ______________ Swollen ankles _______________

Kidney disease _______________ Heart disease ______________ German Measles _______________

Toxemia ______________ Staining _____________ Bleeding _____________ Vomiting ______________

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Rh or other blood incompatibility: ______________________________ Virus:_______________________________

Specify any other diseases present: ____

List any threatened miscarriages or early contractions:____

List any chronic illness(s) during your pregnancy such as diabetes, kidney infection, thyroid, epilepsy, etc.: __

List any other illnesses during pregnancy: ____

____

Hospitalization (dates/where): ____

____

Operations (dates/type): ____

____

Injuries (dates/type): ____

What medications, if any, did you take during this pregnancy? ____

____

Did you consume alcohol during this pregnancy? ❑ yes ❑no If yes, how much and frequency: __________

List any other complications: ____

____

____

List all of your pregnancies in order, including the child to be seen at the clinic. If a pregnancy ended in miscarriage, state at which month. If you have had more than five pregnancies, list on back of this page.

Year	Name	Length of Pregnancy	Birth Weight	Sex	Complications

BIRTH HISTORY

Name of hospital: ____

Did you have a Cesarean Section? ❑ yes ❑no If yes, why? ____

____

How many hours from the first contraction to birth? ____________

Were you given medication? ❑ yes ❑no If yes, what kind? ____

Were you under anesthesia during childbirth? ❑ yes ❑no If yes, what kind? _________________________

____

Was labor induced? ❑ yes ❑no If yes, why? ____

____

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How was labor induced? ____

Was the baby born head first? ❑ yes ❑no Were forceps used? ❑ yes ❑no

Did the baby have any bruises? ❑ yes ❑no

Did the baby have any birthmarks? ❑ yes ❑no If yes, how many? ________________________________

Was this a multiple birth? ❑ yes ❑no If yes, how many? ______________________________________

Did this baby have breathing problems? ❑ yes ❑no Was the cord around the neck? ❑ yes ❑no

Did the baby cry quickly? ❑ yes ❑no

Was the baby's color normal? ❑ yes ❑no If no, was the baby blue or yellow? ______________________

If the baby was yellow (jaundiced), did he/she receive:

Oxygen? ❑ yes ❑no If yes, how long? ____

Transfusions? ❑ yes ❑no If yes, how many? ____

Phototherapy? ❑ yes ❑no If yes, how many days? ____________________________________

Were there any other complications before you took the baby home? ❑ yes ❑no

If yes, what? ____

Was the baby placed in an incubator or a special crib? ❑ yes ❑no If yes, how long? __________________

How long after the birth did you take the baby home? ____

EARLY HISTORY

General Information

Did the baby have any feeding problems? ❑ yes ❑no If yes, please describe: ______________________

____

Was the baby colicky? ❑ yes ❑no If yes, how long?____

Did the baby require formula changes? ❑ yes ❑no If yes, please describe: ________________________

____

Difficulty sucking as an infant? ❑ yes ❑no Difficulty chewing? ❑ yes ❑no

Drooling past 2.5 years? ❑ yes ❑no

Was the baby normally active? ❑ yes ❑no If no, please describe:___________________________________

____

Was the baby limp? ❑ yes ❑no Was the baby stiff? ❑ yes ❑no

Did the baby show unusual trembling? ❑ yes ❑no Did the baby fail to grow normally? ❑ yes ❑no

Did the baby fail to gain weight normally? ❑ yes ❑no

Was this baby different in any way from his/her brothers or sisters? ❑ yes ❑no If yes, please describe: _

____

Motor Milestones

Age sat alone: __________ Age tied shoes: __________ Age walked alone: __________

Age fed self: __________ Age dressed self: __________ Age pedaled tricycle: _________

Age rode bicycle: ____________ Age swam: ___________

Language Milestones

Age spoke first words: ___________ Age put 2-3 words together: ___________

Age used good sentence structure: ___________

Any speech problems? ❑ yes ❑no If yes, describe: ____

____

Toilet Training

Age trained for bladder: __________ Age trained for bowels: __________

Any bed wetting? ❑ yes ❑no If yes, age started: _________ How often? _________

Age controlled: __________

Did child have urine accidents during the day? ❑ yes ❑no Did child have soiling? ❑ yes ❑no

Medical History

Has your child had meningitis or encephalitis? ❑ yes ❑no If yes, at what age? _______________________

Has your child had a head injury? ❑ yes ❑no If yes, was there a loss of consciousness? ❑ yes ❑no

Did your child have any other significant injuries? ❑ yes ❑no If yes, please specify: __________________

____

Has your child ever had a high or prolonged fever? ❑ yes ❑no If yes, please specify: _________________

____

Did your child have frequent ear infections? ❑ yes ❑no

Does your child have any visual defects? ❑ yes ❑no Any hearing defects? ❑ yes ❑no

Does your child have heart disease? ❑ yes ❑no Does your child have asthma? ❑ yes ❑no

Has your child had episodes of unconsciousness? ❑ yes ❑no If yes, please explain: ___________________

____

Has your child been hospitalized? ❑ yes ❑no If yes, please specify: ___________________________________

____

List any other uncommon childhood illnesses your child has had. _______________________________________

____

Does your child frequently complain of any of the following?

Headache ❑ yes ❑no Nausea ❑ yes ❑no Weakness ❑ yes ❑no Dizziness ❑ yes ❑no

Stomachaches ❑ yes ❑no Chronic Constipation ❑ yes ❑no Chronic Diarrhea ❑ yes ❑no

Trouble with vision ❑ yes ❑no Trouble with hearing ❑ yes ❑no

Describe any other frequent complaint(s): ____

____

List any medications that your child has taken in the past for more than a month (include dosage given and reason it was taken): ____

____

____

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List any medications your child is currently taking (including dosage and reason for taking it): _____________

____

____

Complete the information for any of the following which you child has had:

Eye exam: Age ________ Results ____

Hearing exam: Age ________ Results ____

EEG: Age _______ Results ____

List any other special medical tests: ____

____

Have you consulted any medical specialists about your child? ❑ yes ❑no

If yes, who and why: ____

____

____

____

BEHAVIORAL AND SOCIAL HISTORY

Who lives in the home? ____

____

Are there significant marital conflicts? ❑ yes ❑no

Are there significant conflicts between child and parents? ❑ yes ❑no If yes, please describe: __________

____

____

Are there significant conflicts between the children? ❑ yes ❑no If yes, please describe: _______________

____

____

Who disciplines and how? ____

____

How does your child respond to discipline? ____

____

Does your child have difficulty getting along with children his or her own age? ❑ yes ❑no If yes, please explain: ____

Does your child have difficulty getting along with adults? ❑ yes ❑no If yes, please explain: _____________

How does your child occupy him/herself? ____

____

Check the following characteristics that describe your child:

❑ Shy ❑ Immature ❑ Well-behaved ❑ Stubborn ❑ Impulsive

❑ More active than other children ❑ Clumsy using hands ❑ Clumsy walking

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Does your child currently or did your child ever have any of the following:

❑ Temper tantrums ❑ Poor handwriting ❑ Sleep problems ❑ Head banging

❑ Nightmares ❑ Toe walking ❑ Blank spells ❑ Thumb sucking

❑ Falling spells If so, describe: ____

____

❑ Tics or twitching If so, describe: ____

____

Did your child ever have difficulty staying with one activity for a reasonable length of time? ❑ yes ❑no

Did your child ever eat paint, paper, etc.? ❑ yes ❑no

Which hand does your child prefer? ❑ right ❑left At what age was this preference established? ________

Does your child switch hands? ❑ yes ❑no

Has your child had emotional, adjustment, or behavioral problems? ❑ yes ❑no If yes, please explain:

____

Has your child received any psychological or psychiatric treatment? ❑ yes ❑no

If yes, by whom? ____

When? ____________________________ For what reason? ______________________________

____

Have you consulted with anyone about the current problem? ❑ yes ❑no

If yes, with whom? ____

When? ___________________________ Where? ______________________________

____

SCHOOL HISTORY

Did your child attend a nursery school or a preschool program? ❑ yes ❑no

Were there problems? ❑ yes ❑no If yes, please describe: ______________________________

____

Check all problems your child's school has currently reported:

❑ Behavior ❑ Social adjustment ❑ Attention span ❑Following directions

❑Completing assignments ❑Arithmetic ❑ Reading ❑ Spelling ❑ Writing

Does your child like school? ❑ yes ❑no

Is your child in a special education class? ❑ yes ❑no If yes, what kind? ______________________

When was your child placed there? ____

Does your child receive any special services in school (resource room, tutorial, remedial reading, speech, etc.)? ❑ yes ❑no If yes, please describe: ______________________________

____

For how long? ____

Have you gotten any help privately for your child? ❑ yes ❑no If yes, please describe: __________

____

Family History

<u>List children in order of birth</u>

Family Member	Age	Education or Current Grade	Occupation	Health	School or Behavioral Problems
Father					
Mother					

If anyone in your immediate family or other relative has any of the following, please indicate who:

Neurological disease ____

Seizures (epilepsy) ____

Hearing Problems ____

Visual Problems ____

Emotional Problems ____

Mental Retardation ____

Slowness in talking ____

Slowness in walking ____

Hyperactivity ____

Reading Problems ____

Learning Disabilities ____

Problems Similar to Your Child ____

Does any disease run in the family? ❑ yes ❑no If so, describe ___________________________

____

____

Additional Comments:

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