Pediatric Neuropsychology Child Information Form

The following questions are being asked to help us better understand your child. Please complete this form to the best of your knowledge **before your appointment**. Some information may not apply to your child. You can leave it blank or write N/A for not applicable.

**** Please bring a copy of school records (IEP or 504 Plan) or testing to your appointment. ****

Person completing this form: _____ Today's Date: _____

Relationship with child (check one): ☐ Mother ☐ Father ☐ Other: _____

Mailing Address: _____ Phone: _____

_____

CHILD'S INFORMATION

Child's Name: _____ Date of Birth: _____

Race and/or Ethnicity: _____ Age: _____

Sex: ☐ Male ☐ Female ☐ Other

Does the child speak a language **other** than English? ..... ☐ No ☐ Yes

If yes, what language(s)? _____ If yes, what is the language spoken **most** at home? _____

CURRENT CONCERNS

Who referred your child for an evaluation? _____

Briefly describe your **concerns** for your child that led to this evaluation. _____

_____

_____

_____

When did you or others first become concerned? _____

Are there any **specific questions** you are hoping to have answered by this evaluation? _____

_____

_____

Are you concerned that your child **may** have any of these diagnoses?

☐ Autism ☐ ADD/ADHD ☐ Learning Disability/Dyslexia ☐ Other: _____

What do you find **most difficult** about raising your child? _____

What do you **enjoy most** about raising your child? _____

_____

_____

FAMILY INFORMATION

	Birth Mother	Birth Father
Name:	_____	_____
Highest grade completed:	_____	_____
Occupation:	_____	_____

Parents' Relationship: ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Never married

Child's age at divorce or separation: _____

If parents are separated or divorced, **how often** does the other parent see this child?

❒ Weekly or more often ❒ Once or twice per month ❒ Few times per year ❒ Never

Is your child: ❒ Adopted ❒ In foster care

If **adopted**, how old was your child when they were adopted? _____

If in **foster care**, how long have they been in foster care? _____

If in **foster care**, how long have they been at their current placement? _____

Please include information about other parents or caregivers involved in your child's care:

	Circle One: Adoptive, Foster, Step-parent, or Other: _____	**Circle One:** Adoptive, Foster, Step-parent, or Other: _____
Name:	_____	_____
Highest grade completed:	_____	_____
Occupation:	_____	_____

Please list all this **child's siblings** and their relationship to the child:

Name	Age	Sex	Full	Half	Step	Lives in the home?	
1. _____	_____	_____	❒	❒	❒	___ No	___ Yes
2. _____	_____	_____	❒	❒	❒	___ No	___ Yes
3. _____	_____	_____	❒	❒	❒	___ No	___ Yes
4. _____	_____	_____	❒	❒	❒	___ No	___ Yes

Please list any **other persons** living in the home:

Name	Relation to Child
1. _____	_____
2. _____	_____

Describe any **religious or cultural values** that would be important to understand about your family:_____

_____

_____

PREGNANCY & DELIVERY

Mother's age at delivery of this child: _____ **Father's age** at delivery of this child: _____

Were there any **complications** during the pregnancy? ❒ No ❒ Yes

If yes, please describe: _____

Did the mother take any **medications** during the pregnancy? ❒ No ❒ Yes

If yes, please describe: _____

Did the mother use any of the following during the pregnancy?

Cigarettes ❒ No ❒ Yes, _____ cigarettes per … ❒ Day ❒ Week

Alcohol ❒ No ❒ Yes, _____ drinks per … ❒ Day ❒ Week ❒ Month

Marijuana ❒ No ❒ Yes, please describe the type and frequency of use: _____

Drugs ❒ No ❒ Yes, please describe the type and frequency of use: _____

The child was born: ❒ on time ❒ early ❒ late

How long was the pregnancy? _____ weeks

Type of **labor**: ❒ spontaneous ❒ induced

Type of **delivery**: ❒ vaginal ❒ planned C-section ❒ emergency C-section

If there was an **emergency C-section** explain why: _____

How much did the baby **weigh**? _____

Were there **complications** in the first weeks (e.g., breathing, jaundice, seizures)? ❒ No ❒ Yes

If yes, please describe: _____

_____

Did your child need to go to the **NICU**? ❒ No ❒ Yes

If yes, what types of procedures did your baby need? _____

_____

DEVELOPMENTAL INFORMATION

Are (or were there) any **concerns** about your child's **early** development? ❒ No ❒ Yes

If yes, please explain: _____

Has your child ever lost or stopped doing something that they used to do well? ❒ No ❒ Yes

If yes, please explain: _____

Did your child receive **Early Steps or Early Childhood Intervention (ECI)**? ❒ No ❒ Yes

If yes, what ages: _____

Give approximate ages when your child did the following:

Sat without support	_____	Spoke first words	_____	Toilet Trained	_____
Crawled	_____	Put 2-3 words together	_____		
Walked	_____	Spoke in sentences	_____		

Did (or does) your child have problems with any of the following **motor skills**?

❒ Clumsier than other children
❒ Throwing, catching, or kicking balls
❒ Using stairs
❒ Using buttons and/or zippers
❒ Handwriting
❒ Using utensils (i.e., spoons)

What **hand** does your child use most? ❒ Right ❒ Left ❒ Both, ambidextrous

Is there anyone in the family that is left-handed? ❒ No ❒ Yes, who? _____

Did (or does) your child have any of the following **speech/language problems**?

❒ Speech is hard to understand (articulation)
❒ Limited vocabulary
❒ Trouble thinking of the words they want to say
❒ Poor grammar

What **therapies** has your child received **(Check all that apply)**:

Therapy	Location	Past	Current	Age(s)	How often do they get this therapy now? (i.e., 1 time a week for 30 minutes)
Speech/Language Therapy	Early Steps or ECI	❒ Yes	❒ Yes		
	School	❒ Yes	❒ Yes		
	Outpatient Clinic ❒ TGH ❒ Other: _____	❒ Yes	❒ Yes		
Occupational Therapy	Early Steps or ECI	❒ Yes	❒ Yes		
	School	❒ Yes	❒ Yes		
	Outpatient Clinic ❒ TGH ❒ Other: _____	❒ Yes	❒ Yes		
Physical Therapy	Early Steps or ECI	❒ Yes	❒ Yes		
	School	❒ Yes	❒ Yes		
	Outpatient Clinic ❒ TGH ❒ Other: _____	❒ Yes	❒ Yes		

Please include **any other** therapies (i.e., feeding) your child has received:_____

MEDICAL INFORMATION

List any serious illnesses, injuries, hospitalizations, concussions, or surgeries.

Date or Age	Explain the event
_____	_____
_____	_____
_____	_____
_____	_____

Current medications or supplements	**Reason(s) for the medication(s)**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are there **other medications** your child previously took but have now stopped? ❒ No ❒ Yes
If yes, what were they and why were they stopped? _____

Has **vision** been checked within the past year? ❒ No ❒ Yes
Does your child wear glasses or contacts for reading/**seeing up close** (farsighted)? ❒ No ❒ Yes
Does your child wear glasses or contacts for distance/**seeing far away** (nearsighted)? ❒ No ❒ Yes
Has your child had any **surgeries** on their eyes? ❒ No ❒ Yes
Describe any other vision problems: _____

Has **hearing** been checked within the past year? ❒ No ❒ Yes
Does your child wear hearing aids? ❒ No ❒ Yes
Does (or did) your child have ear tubes? ❒ No ❒ Yes
Describe any other hearing problems: _____ ❒ No ❒ Yes

Check all that apply regarding your child's **appetite**:

- ❒ No problems with appetite
- ❒ Eats too little
- ❒ Eats too much
- ❒ Has food allergies
- ❒ Picky eater
- ❒ Recent large weight **loss**
- ❒ Recent large weight **gain**
- ❒ Other: _____

About what **time** does your child **go to asleep** on:
School nights: _____
Weekends: _____

About what **time** does your child **wake up** on weekends:
School nights: _____
Weekends: _____

Does your child take **naps**? ❒ No ❒ Yes If yes, **when**: _____

Check all that apply regarding your child's **sleep**:

- ❒ No problems with sleep
- ❒ Difficulty with bedtime routine
- ❒ Unable to sleep alone
- ❒ Bedwetting
- ❒ Difficulty **falling** asleep
- ❒ Difficulty **staying** asleep
- ❒ Needs little sleep
- ❒ Other: _____

MEDICAL INFORMATION CONTINUED

Has your child or any of his or her relatives had any of the following conditions or problems? (Relatives include your child's biological parents, brothers, sisters, grandparents, aunts, uncles, and cousins.)

	Does **your child** have this condition?		Does a **relative** have This condition?	
Condition	YES	Identified when? **(age or date)**	YES	Relationship to child
Autism Spectrum Disorder	☐	_____	☐	_____
Developmental Delays	☐	_____	☐	_____
Language/Speech Problem	☐	_____	☐	_____
Attention Deficit/Hyperactivity Disorder (ADHD)/ADD	☐	_____	☐	_____
Learning problems with reading or math	☐	_____	☐	_____
Diagnosed Learning Disability or Dyslexia	☐	_____	☐	_____
Intellectual Disability/mental retardation	☐	_____	☐	_____
Tics or Tourette's syndrome	☐	_____	☐	_____
Anxiety	☐	_____	☐	_____
Obsessive Compulsive Disorder (OCD)	☐	_____	☐	_____
Depression	☐	_____	☐	_____
Bipolar disorder	☐	_____	☐	_____
Schizophrenia	☐	_____	☐	_____
Suicide	☐	_____	☐	_____
Hospitalization for mental illness	☐	_____	☐	_____
Epilepsy (seizures)	☐	_____	☐	_____
Genetic disorders (e.g., Down Syndrome, NF1)	☐	_____	☐	_____
Sickle Cell Disease	☐	_____	☐	_____
Multiple Sclerosis	☐	_____	☐	_____
Other: _____	☐	_____	☐	_____

STRESSORS

Have any of the following events happened within the past 12 months?

- ❒ Parents divorced or separated
- ❒ Parent changed job
- ❒ New baby at home
- ❒ Family accident or illness
- ❒ Death in family
- ❒ Family moved
- ❒ Family financial problems
- ❒ Other: _____

Please explain: _____

_____

Have any of the following experiences ever happened to your child?

- ❒ Experienced a traumatic event
- ❒ Physical or sexual abuse
- ❒ Neglect
- ❒ Child Protective Services (CPS) involvement
- ❒ Been in trouble with the law

Please explain: _____

_____

SCHOOL INFORMATION

Did your child attend or is attending?

❒ Daycare ❒ Preschool/Pre-Kindergarten ❒ Kindergarten ❒ Head Start

Were there (or are there) any problems with learning or behavior during Preschool and/or Kindergarten?

❒ No ❒ Yes, explain: _____

Current School:

What is the name of your child's current **school**: _____

Name of **School District**:

❒ Hillsborough County ❒ Pinellas County ❒ Other:_____

How **long** has your child been at this school?_____

What other schools has your child attended before?_____

What **grade** is your child in? _____

Has your child ever **repeated** a grade? ❒ No ❒ Yes, which grade(s): _____

Has your child ever **skipped** a grade? ❒ No ❒ Yes, which grade(s): _____

Overall, how does your child perform in school? Grades? GPA?

_____

Has your child taken? ❒ Honors classes ❒ Pre-AP/AP classes ❒ IB Classes

What is your child's **best** class? _____

What is your child's **worst** class? _____

Has your child **failed any standardized testing** (i.e., Florida Standards Assessments (FSA); End of Year Exams/EOC)?

❒ No ❒ Yes, explain: _____

Has your child ever taken the **Pre-SAT, SAT, or ACT**?

❒ No ❒Yes, their **score** was: _____

Teachers describe (or have described) problems in: (Check all that apply)

❒ Reading	❒Finishing homework	❒ Attention/concentration
❒ Spelling	❒Turning in homework	❒ Organization
❒ Writing	❒Studying for tests	❒ Following directions
❒ Math	❒Taking tests	❒ Other:_____

How far do you expect your child to go in school? _____

How would you describe your child's intelligence?

❒ Below Average ❒ Average ❒ Above Average

SCHOOL INFORMATION CONTINUED

Has your child **ever been tested before** (e.g., special education, intellectual, academic, developmental, speech/language, or psychological)? ❒ No ❒ Yes

If yes, please explain **who completed the testing** and the **results** of that evaluation: _____

_____

_____

Please indicate any **services** your child currently receives or received in the past:

			When: (ages or dates)
Individualized Education Plan (IEP)	❒ Current	❒ Past	_____
504 Plan	❒ Current	❒ Past	_____
Response to Intervention (RtI)	❒ Current	❒ Past	_____
Title I Services	❒ Current	❒ Past	_____
Resource Room or Pull-outs	❒ Current	❒ Past	_____
Co-taught classroom	❒ Current	❒ Past	_____
Tutoring	❒ Current	❒ Past	_____
Behavior Intervention Plan (BIP)	❒ Current	❒ Past	_____
Individual Aide	❒ Current	❒ Past	_____
Other: _____	❒ Current	❒ Past	_____

If your child has an IEP, what is the **eligibility** category? (Check all that apply.)

- ❒ Autism Spectrum Disorder (ASD)
- ❒ Deaf or Hard of Hearing (DHH)
- ❒ Developmentally Delayed
- ❒ Dual-Sensory Impairment (DSI)
- ❒ Emotional Disturbance (E/BD)
- ❒ Hospital Homebound (HH)
- ❒ Intellectual Disability (InD)
- ❒ Language Impairment (LI)
- ❒ Orthopedic Impairment (OI)
- ❒ Other Health Impairment (OHI)
- ❒ Specific Learning Disability (SLD)
- ❒ Speech Impairment (SI)
- ❒ Traumatic Brain Injury (TBI)
- ❒ Vision Impairment (VI)
- ❒ I don't know or unsure

Please describe any **accommodations** your child gets for school (i.e., extra time):_____

_____

_____

_____

_____

SOCIAL INFORMATION

Has your child ever had a **mental health evaluation or received treatment** by a psychologist, psychiatrist, counselor, or social worker? ❒ No ❒ Yes (please explain below)

Name of Professional	Dates (or child's age)	Reason for the evaluation or treatment
_____	_____	_____
_____	_____	_____

What words would you use to describe your child's **personality**? _____

How would you describe your child's mood/feelings **most of the time?**

❑ Happy ❑ Calm ❑ Sad ❑ Worried/Anxious ❑ Irritable/Moody

Are you concerned about your child's **behavior**? ❒ No ❒ Yes

If yes, please explain: _____

_____

_____

Select each behavior/parenting strategy that you usually use (Check all that apply):

❒ Ignore problem behavior ❒ Redirect child to another activity ❒ Time out
❒ Scold child ❒ Send child to their room ❒ Reward system
❒ Take away activity or electronics ❒ Spank child ❒ Other:_____

What have you found most helpful in disciplining your child?_____

_____

How **confident** are you in disciplining your child?

❑ Not ❑ Somewhat ❑ Confident ❑ Very Confident

Are you concerned about your child's **social skills** or ability to get along with others? ❒ No ❒ Yes

If yes, please explain:

_____

_____

Does your child have a **best friend**? ❒ No ❒ Yes

Does your child have problems **making friends**? ❒ No ❒ Yes

Does your child have problems **keeping friends**? ❒ No ❒ Yes

Who does your child get along with best?

❒ Older children ❒ Children of the same age ❒ Younger children

Is your child involved in any **clubs, organizations, sports teams, or religious activities**? ❒ No ❒ Yes

If yes, please describe: _____

What are your child's favorite activities during free time? _____

Thank you for completing this form.
It will help us understand how to best help your child.