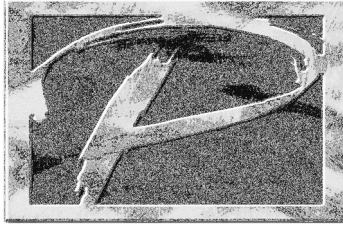


# PROVIDENCE

## BEHAVIORAL HEALTH



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### CHILD NEUROPSYCHOLOGY QUESTIONNAIRE

*Please fill out the following questionnaire to the best of your ability.*

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Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Date of Evaluation: \_\_\_\_\_ Person who referred you for evaluation: \_\_\_\_\_

Name of person filling out this questionnaire: \_\_\_\_\_

Child's Pediatrician and address: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth of Insured: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Insurance ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

#### Notes:

#### I. REFERRAL

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Reason(s) you are requesting an evaluation \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In your opinion, the major causes of your child's difficulties are \_\_\_\_\_

\_\_\_\_\_

Describe some of your child's strengths \_\_\_\_\_

\_\_\_\_\_

Describe some of your child's weaknesses \_\_\_\_\_

\_\_\_\_\_

Is there any legal involvement? Y/N Please Explain: \_\_\_\_\_

Who has legal custody? \_\_\_\_\_

## II. HISTORY

### A. Pregnancy and Birth History:

Age of mother \_\_\_\_\_ and father \_\_\_\_\_ at delivery? How many prior pregnancies? \_\_\_\_\_  
 How many prior miscarriages? \_\_\_\_\_ Was a fertility specialist consulted? \_\_\_\_\_ Procedures? \_\_\_\_\_  
 Any known health problems of mother during pregnancy? \_\_\_\_\_ toxemia? \_\_\_\_\_  
 hypertension? \_\_\_\_\_ gestational diabetes? \_\_\_\_\_ trauma? \_\_\_\_\_ fever/rash? (e.g., flu measles?) \_\_\_\_\_  
 depression or other emotional problems? \_\_\_\_\_ blood incompatibility? \_\_\_\_\_ injury? \_\_\_\_\_  
 excessive weight gain? \_\_\_\_\_ other? \_\_\_\_\_

List any vitamins, supplements, medications, tobacco use, alcohol use, or drugs taken by mother during pregnancy

Name	Before	During	After	Reason, if prescribed

Delivery was vaginal \_\_\_\_\_ Cesarean \_\_\_\_\_ (reason \_\_\_\_\_)

Baby was full term \_\_\_\_\_ premature \_\_\_\_\_ (\_\_\_\_\_ weeks gestation), late \_\_\_\_\_ (\_\_\_\_\_ weeks gestation)

Birth Weight \_\_\_\_\_ pounds. \_\_\_\_\_ ounces.; length \_\_\_\_\_ inches; Approximate length of labor: \_\_\_\_\_ hours

Any birth complications? (e.g., feet first/cord around neck/meconium staining/lacking oxygen-blue/jaundice-yellow) \_\_\_\_\_

Did baby breathe spontaneously? \_\_\_\_\_; was oxygen required? \_\_\_\_\_

Apgar scores if known \_\_\_\_\_ In Intensive Care Nursery? \_\_\_\_\_

How old was baby at discharge from the hospital after birth? \_\_\_\_\_

How long was mother in hospital after birth? \_\_\_\_\_

Medical problems after discharge (e.g., jaundice, fever, transfusion, surgery) \_\_\_\_\_

Describe any problem in the first few months? \_\_\_\_\_

Did mother experience postpartum (after birth) depression? \_\_\_\_\_

### B. Developmental History:

#### Motor:

Age [in months] when the child sat alone \_\_\_\_\_; crawled \_\_\_\_\_; stood alone \_\_\_\_\_ and walked alone \_\_\_\_\_

Was your child slow to develop motor skills or awkward compared to siblings/friends (e.g., running, skipping, climbing, biking, playing ball?) \_\_\_\_\_

Handedness: right \_\_\_\_\_ left \_\_\_\_\_ both \_\_\_\_\_ (explain) \_\_\_\_\_

Family history of left-handedness (list relatives)? \_\_\_\_\_

Speech/Language:

Age spoke first word \_\_\_\_\_ put 2-3 words together \_\_\_\_\_

Speech delays/problems (e.g., stutters, difficult to understand)? \_\_\_\_\_

Oral-motor problems (e.g., late drooling, poor sucking, poor chewing?) (describe) \_\_\_\_\_

Was child slow to learn the alphabet? \_\_\_\_\_ name colors? \_\_\_\_\_ count? \_\_\_\_\_

Other language spoken at home (besides English)? \_\_\_\_\_

Besides English, my child is fluent in \_\_\_\_\_

Describe any sensory issues (e.g., sensitivity to textures, tags, etc.) \_\_\_\_\_

Please list any services your child has received:

Service Provided	Start Date	End Date	Provider Name
Occupational Therapy			
Physical Therapy			
Speech/Language Therapy			
Other:			

Toileting:

Age when toilet trained \_\_\_\_\_ Problems with bedwetting?, urine accidents?, soiling?, Until what age? \_\_\_\_\_

Any current problems? \_\_\_\_\_

**C. Medical History:**

Has vision been checked? (Date) \_\_\_\_\_ Any problems: \_\_\_\_\_

Has hearing been checked? (Date) \_\_\_\_\_ Any problems: \_\_\_\_\_

List serious illnesses/injuries/hospitalizations/surgeries

Date	Incident (explain)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Provide information on any tests/procedures your child has undergone (e.g., CT, MRI, EEG, lead poisoning, etc.)

Technique/Test	Date	Results

Is there a history of (please explain in space to the right checkmark):

Concern	Y/N Comments	Concern	Y/N Comments
Failure-to-Thrive		Ear infections	
Febrile Seizures (fever)		Sleep difficulties	
Epilepsy		Sleep walking/talking	
Staring Spells		Night Terrors or Nightmares	
Lead poisoning/toxic ingestions		Eating difficulties/eating disorder	
Meningitis or encephalitis		Tics or twitching	
Asthma or allergies		Repetitive movement (e.g., hand flapping)	
Diabetes		Acting without thinking?	
Loss of consciousness		Nail biting	
Abdominal pain		Clumsiness	
Headaches		Head banging	
Purposefully hurting self		Hyperactive	
Appetite			

Describe head injuries: (e.g., date, type, loss of consciousness, resulting changes in behavior?) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Current medications:

Medication	Dosage	Frequency	Length Taking	Purpose	Side Effects

Has your child ever used drugs or alcohol? \_\_\_\_\_

Is there a history of neurological illness in any family member (e.g., seizure, Parkinson's, Alzheimer's, etc.)? \_\_\_\_\_

Does anyone else in the family have a problem similar to your child's reason for referral? \_\_\_\_\_  
 \_\_\_\_\_

**D. Psychological & Psychiatric History:**

Have you previously had direct contact with any social agency, psychologist, psychiatrist, clinic, or private agency?

Professional/Practice	Address	Dates	Purpose

Is there a family history of psychiatric condition(s) (e.g., depression, anxiety, bipolar, schizophrenia) ?

\_\_\_\_\_

\_\_\_\_\_

Has your child ever received cognitive testing (e.g., intelligence or achievement tests?) \_\_\_\_\_

Has your child ever received other psychological testing? (e.g., behavioral, personality) \_\_\_\_\_

If your child has been previously evaluated, do you have a copy of the report? \_\_\_\_\_ or contact information for the professional who evaluated your child? \_\_\_\_\_

**E. Educational History:**

Current school and address: \_\_\_\_\_

Grade: \_\_\_\_\_ Placement: regular \_\_\_\_\_ resource \_\_\_\_\_ special education \_\_\_\_\_

Other \_\_\_\_\_

Any grades that were skipped or repeated? \_\_\_\_\_

Is there a history of learning difficulties in any family member? \_\_\_\_\_

\_\_\_\_\_

Teachers report problems in:

Area	Y/N	Comments	Area	Y/N	Comments
Reading Decoding			Basic Math Facts		
Reading Comprehension			Math Concepts (e.g., time, money)		
Spelling			Written Expression		
Oral Expression			Getting along with others		

Please describe the above noted problem(s) \_\_\_\_\_

\_\_\_\_\_

Describe school (e.g., academic, social, behavioral) concerns:

Grades	Concerns
Preschool	
Primary (K-2)	
Intermediate (3-5)	
Middle (6-8)	
High (9-12)	

Do teachers report problems that you do not notice? \_\_\_\_\_

**F. Social History**

Name of Parents

Mother \_\_\_\_\_ Age: \_\_\_\_\_ Education: \_\_\_\_\_

Occupation \_\_\_\_\_

Check all that apply:

History of:  Depression  Anxiety  Bipolar  Seizures  Parkinson's

History of learning difficulties? \_\_\_\_\_

Father \_\_\_\_\_ Age: \_\_\_\_\_ Education: \_\_\_\_\_

Occupation \_\_\_\_\_

Check all that apply:

History of:  Depression  Anxiety  Bipolar  Seizures  Parkinson's

History of learning difficulties? \_\_\_\_\_

Parents are: Married \_\_\_\_\_ How Long? \_\_\_\_\_ Separated \_\_\_\_\_ When? \_\_\_\_\_

Divorced \_\_\_\_\_ When? (Custody is with \_\_\_\_\_)

Re-married \_\_\_\_\_ How Long? \_\_\_\_\_ Deceased \_\_\_\_\_ When? \_\_\_\_\_

Child is: Biological \_\_\_\_\_ Adopted (at age \_\_\_\_\_) Foster \_\_\_\_\_ Since \_\_\_\_\_

Siblings (name, age) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Others living in home \_\_\_\_\_

\_\_\_\_\_

Is child in Child Care? \_\_\_\_\_ How many hours/day? \_\_\_\_\_

Has your child experienced death or separation from a loved one? \_\_\_\_\_ Explain \_\_\_\_\_

\_\_\_\_\_

Has your child experienced abuse or trauma? \_\_\_\_\_ Explain \_\_\_\_\_

\_\_\_\_\_

Are there any significant family or marital conflicts? (Explain) \_\_\_\_\_

\_\_\_\_\_

Have there been any other changes in your family that may impact your child's functioning? \_\_\_\_\_

\_\_\_\_\_

How many hours per day does your child spend watching TV/playing video games? \_\_\_\_\_

How much time do you spend reading to or with your child? \_\_\_\_\_ How much time does your child spend reading

for pleasure? \_\_\_\_\_ How much time do adults in home spend reading for pleasure? \_\_\_\_\_

**G. Behavioral History**

Does your child get along well with other children? \_\_\_\_\_ adults? \_\_\_\_\_ have friends? \_\_\_\_\_

keep friends? \_\_\_\_\_ understand gestures? \_\_\_\_\_ have a good sense of humor? \_\_\_\_\_

Understand social cues well (e.g., knows when others are angry, in discomfort?) \_\_\_\_\_

Does your child have any peculiar or unusually intense areas of interest? \_\_\_\_\_

What are your child's hobbies and interests? \_\_\_\_\_

In which, if any, extracurricular activities does your child participate? \_\_\_\_\_

Please provide any pertinent information regarding your child's social behavior: \_\_\_\_\_

\_\_\_\_\_

Are there any other habits or behaviors of concern? \_\_\_\_\_

What other information that would be helpful for the evaluation? \_\_\_\_\_

\_\_\_\_\_

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