

CHILD NEUROPSYCHOLOGICAL HISTORY

Child's Name: _____ Date: _____

Address (Street, City, State, Zip): _____

Parent's or guardian phone: (H) _____ (W) _____

Age _____ Birthdate _____ Religion _____

Sex _____ Ethnic or racial background _____

Grade and school _____

Special Placement (if any) _____

Hand child uses for writing or drawing: Right _____ Left _____ Switches between them _____

Primary language _____ Secondary language _____

Medical diagnosis (if any) (1) _____

(2) _____

(3) _____

(4) _____

Who referred the child for this testing? _____

Briefly describe the problem(s)

(1) _____

(2) _____

(3) _____

(4) _____

What specific questions would you like answered by this evaluation?

(1) _____

(2) _____

(3) _____

(4) _____

THIS FORM HAS BEEN COMPLETED BY:

Name _____ Relationship to child _____

Address _____

Phone (H) _____ (W) _____

SYMPTOM SURVEY

For each symptom that applies to the child, place a check in the box. Compare the child to other children of the same age. Then, check if this is a NEW symptom (within the past year OR after the injury/illness) or an OLD symptom (over one year OR before the injury or illness). Add any comments next to the item.

1) PROBLEM SOLVING

- | √ | New | Old | |
|--------------------------|-----|-----|--|
| <input type="checkbox"/> | ___ | ___ | Difficulty figuring out how to do new things |
| <input type="checkbox"/> | ___ | ___ | Difficulty making decisions |
| <input type="checkbox"/> | ___ | ___ | Difficulty planning ahead |
| <input type="checkbox"/> | ___ | ___ | Difficulty solving problems a younger child can do |
| <input type="checkbox"/> | ___ | ___ | Disorganized in his/her approach to problems |
| <input type="checkbox"/> | ___ | ___ | Difficulty understanding explanations |
| <input type="checkbox"/> | ___ | ___ | Difficulty doing things in the right order (sequencing) |
| <input type="checkbox"/> | ___ | ___ | Difficulty verbally describing the steps involved in doing something |
| <input type="checkbox"/> | ___ | ___ | Difficulty completing an activity in a reasonable period of time |
| <input type="checkbox"/> | ___ | ___ | Difficulty changing a plan or activity when necessary |
| <input type="checkbox"/> | ___ | ___ | Is slow to learn new things |
| <input type="checkbox"/> | ___ | ___ | Difficulty switching from one activity to another activity |
| <input type="checkbox"/> | ___ | ___ | Easily frustrated |
| <input type="checkbox"/> | ___ | ___ | Other problem solving difficulties _____ |

2) SPEECH, LANGUAGE, AND MATH SKILLS

- | √ | New | Old | |
|--------------------------|-----|-----|---|
| <input type="checkbox"/> | ___ | ___ | Difficulty speaking clearly |
| <input type="checkbox"/> | ___ | ___ | Difficulty finding the right word to say |
| <input type="checkbox"/> | ___ | ___ | Not talking |
| <input type="checkbox"/> | ___ | ___ | Rambles on and on without saying much |
| <input type="checkbox"/> | ___ | ___ | Jumps from topic to topic |
| <input type="checkbox"/> | ___ | ___ | Odd or unusual language or vocal sounds |
| <input type="checkbox"/> | ___ | ___ | Difficulty understanding what others are saying |
| <input type="checkbox"/> | ___ | ___ | Difficulty understanding what h/she is reading |
| <input type="checkbox"/> | ___ | ___ | Difficulty writing letters or words |
| <input type="checkbox"/> | ___ | ___ | Difficulty reading letters or words |
| <input type="checkbox"/> | ___ | ___ | Difficulty with spelling |
| <input type="checkbox"/> | ___ | ___ | Difficulty with math |
| <input type="checkbox"/> | ___ | ___ | Other speech, language, or math problems: _____ |

3) SPATIAL SKILLS

- | √ | New | Old | |
|--------------------------|-----|-----|---|
| <input type="checkbox"/> | ___ | ___ | Confusion telling right from left |
| <input type="checkbox"/> | ___ | ___ | Has difficulty with puzzles, Legos, blocks, or similar games |
| <input type="checkbox"/> | ___ | ___ | Problems drawing or copying |
| <input type="checkbox"/> | ___ | ___ | Doesn't know his/her colors |
| <input type="checkbox"/> | ___ | ___ | Difficulty dressing (not due to physical disability) |
| <input type="checkbox"/> | ___ | ___ | Problems finding his/her way around places he/she has been to before |
| <input type="checkbox"/> | ___ | ___ | Difficulty recognizing objects |
| <input type="checkbox"/> | ___ | ___ | Seems unable to recognize facial or body expressions of disapproval or emotions |
| <input type="checkbox"/> | ___ | ___ | Gets lost easily |
| <input type="checkbox"/> | ___ | ___ | Other spatial problems: _____ |

4) AWARENESS AND CONCENTRATION

- | | | | |
|---|-----|-----|--|
| √ | New | Old | |
| □ | ___ | ___ | Easily distracted by: Sounds ___ Sights ___ Physical Sensations ___ |
| □ | ___ | ___ | Mind appears to go blank at times |
| □ | ___ | ___ | Loses train of thought |
| □ | ___ | ___ | Difficulty concentrating on what others say, but can sit in front of a TV for long periods |
| □ | ___ | ___ | Attention starts out OK but can't keep it up |
| □ | ___ | ___ | Other attention or concentration problems: _____ |

5) MEMORY

- | | | | |
|---|-----|-----|---|
| √ | New | Old | |
| □ | ___ | ___ | Forgets where he/she leaves things |
| □ | ___ | ___ | Forgets things that happened recently (e.g., last meal) |
| □ | ___ | ___ | Forgets things that happened days/weeks ago |
| □ | ___ | ___ | Forgets what he/she is supposed to be doing |
| □ | ___ | ___ | Forgets names more than most people do |
| □ | ___ | ___ | Forgets school assignments |
| □ | ___ | ___ | Forgets instructions |
| □ | ___ | ___ | Other memory problems _____ |

6) MOTOR AND COORDINATION

- | | | | | | | |
|---|-----|-----|--|--------------------------------|------|------------|
| | | | | Check the side this occurs on: | | |
| √ | New | Old | | Right | Left | Both Sides |
| □ | ___ | ___ | Poor fine motor skills (e.g., using a pencil or crayon) | ___ | ___ | ___ |
| □ | ___ | ___ | Clumsy | ___ | ___ | ___ |
| □ | ___ | ___ | Weakness | ___ | ___ | ___ |
| □ | ___ | ___ | Tremor | ___ | ___ | ___ |
| □ | ___ | ___ | Muscles are tight or spastic | ___ | ___ | ___ |
| □ | ___ | ___ | Odd movements (posturing, peculiar hand movements, etc.) | ___ | ___ | ___ |
| □ | ___ | ___ | Drops things more than most children | | | |
| □ | ___ | ___ | Has an unusual walk | | | |
| □ | ___ | ___ | Problems running | | | |
| □ | ___ | ___ | Balance problems | | | |
| □ | ___ | ___ | Other motor or coordination problems: _____ | | | |

7) SENSORY

- | | | | | | | |
|---|-----|-----|--|--------------------------------|------|------------|
| | | | | Check the side this occurs on: | | |
| √ | New | Old | | Right | Left | Both Sides |
| □ | ___ | ___ | Needs to squint or move closer to page to read | ___ | ___ | ___ |
| □ | ___ | ___ | Problems seeing objects | ___ | ___ | ___ |
| □ | ___ | ___ | Loss of feeling | | | |
| □ | ___ | ___ | Problems hearing sounds | | | |
| □ | ___ | ___ | Difficulty telling hot from cold | | | |
| □ | ___ | ___ | Difficulty smelling odors | | | |
| □ | ___ | ___ | Difficulty tasting food | | | |
| □ | ___ | ___ | Overly sensitive to: Touch ___ Light ___ Noise ___ | | | |
| □ | ___ | ___ | Other sensory problems: _____ | | | |

8) PHYSICAL

√	New	Old		How often?
<input type="checkbox"/>	___	___	Frequently complains of headaches or nausea	_____
<input type="checkbox"/>	___	___	Has dizzy spells	_____
<input type="checkbox"/>	___	___	Has pains in joints. <i>Where?</i> _____	_____
<input type="checkbox"/>	___	___	Excessive tiredness	
<input type="checkbox"/>	___	___	Frequent urination or drinking	
<input type="checkbox"/>	___	___	Other physical problems: _____	

9) BEHAVIOR

√	New	Old	
<input type="checkbox"/>	___	___	Aggressive
<input type="checkbox"/>	___	___	Attached to things, not people
<input type="checkbox"/>	___	___	Bedwetting
<input type="checkbox"/>	___	___	Bizarre behavior
<input type="checkbox"/>	___	___	Bowel movements in underwear
<input type="checkbox"/>	___	___	Dependent
<input type="checkbox"/>	___	___	Depressed
<input type="checkbox"/>	___	___	Eating habits are poor
<input type="checkbox"/>	___	___	Emotional
<input type="checkbox"/>	___	___	Fearful
<input type="checkbox"/>	___	___	Immature
<input type="checkbox"/>	___	___	Nervous
<input type="checkbox"/>	___	___	Nightmares, night terrors, sleepwalks
<input type="checkbox"/>	___	___	Quiet
<input type="checkbox"/>	___	___	Resists change
<input type="checkbox"/>	___	___	Risk-taking
<input type="checkbox"/>	___	___	Self-mutilates
<input type="checkbox"/>	___	___	Self-stimulates
<input type="checkbox"/>	___	___	Shy and withdrawn
<input type="checkbox"/>	___	___	Sleeping habits are poor
<input type="checkbox"/>	___	___	Swears a lot
<input type="checkbox"/>	___	___	Unmotivated
<input type="checkbox"/>	___	___	Other unusual behavior _____

Below, check all the descriptions of the child that have been present for at least the **past 6 months**. These behaviors should occur more frequently than in other children of the same age.

- _____ Careless
- _____ Is easily distracted
- _____ Has a hard time concentrating for long periods
- _____ Rarely follows others' instructions
- _____ Doesn't listen to other people
- _____ Goes from one activity to another without finishing anything
- _____ Seems like he/she frequently is losing things that are needed for school
- _____ Forgetful in daily activities
- _____ Seems disorganized
- _____ Is very fidgety
- _____ Can't remain seated
- _____ Can't wait for his/her turn when playing with others
- _____ Answers before he/she hears the whole question

- _____ Frequently makes noise when playing
- _____ Seems like he/she is always talking
- _____ Is often rude or interrupts others
- _____ Seems like driven by a motor
- _____ Can't seem to play quietly
- _____ Frequently does dangerous things without considering the consequences
- _____ Loses temper easily
- _____ Argues with adults
- _____ Refuses to comply with requests
- _____ Easily blames others for mistakes and problems
- _____ Easily annoyed or irritated
- _____ Seems angry and resentful
- _____ Steals things without people knowing on several occasions
- _____ Often runs away from his parents' home and stays away overnight
- _____ Easily lies to others
- _____ Fire setting
- _____ Doesn't go to school
- _____ Breaks into other people's property
- _____ Destroys other people's property in some manner other than by fire
- _____ Is cruel to animals
- _____ Has forcible sexual relations with others
- _____ When fighting, has used a weapon on more than one occasion
- _____ Starts fights with others
- _____ Will steal directly from people
- _____ Is cruel to other people

- 10) Overall, the child's symptoms have developed: _____ Slowly _____ Quickly
- 11) The symptoms occur: _____ Occasionally _____ Often
- 12) Over the past 6 months the symptoms have: _____ Stayed about the same _____ Worsened

PREGNANCY

- 13) Mother's age at birth: _____ Father's age at birth: _____
- 14) **Before** the pregnancy, what medications (prescribed or over-the-counter) did the mother take?
List all medications used: _____
- 15) **While** pregnant, what medications (prescribed or over-the-counter) did the mother take?
List all medications used: _____
- 16) How often did the mother see her doctor during the pregnancy?
Regularly (as scheduled by the doctor) _____ Rarely _____ Not at all _____
- 17) During the pregnancy, which of the following did the mother use?

	Amount and Daily Frequency
_____ Alcohol	_____
_____ Caffeine (coffee, colas, etc.)	_____
_____ Marijuana	_____

____ Recreational drugs (cocaine, heroin, etc.) _____
____ Tobacco _____

18) During pregnancy, the mothers diet was: Good ____ Poor ____
If poor, explain: _____

19) The mother's general physical health during the pregnancy was: Good ____ Poor ____
If poor, explain: _____

20) About how much weight did the mother gain while she was pregnant? _____ lbs.

21) During this pregnancy, check all the mother had:

- ____ Accident
- ____ Anemia
- ____ Bleeding (severe or frequent spotting)
- ____ Diabetes
- ____ High blood pressure
- ____ Illnesses or infections
- ____ Preeclampsia, eclampsia, or toxemia
- ____ Psychological problems
- ____ Surgery
- ____ Vomiting (severe or frequent)

22) How many pregnancies did the mother have prior to this one?

Number of live births: _____
Number of miscarriages: _____
Number of abortions _____

BIRTH

23) Was the child born:

Early ____ How early? ____ weeks
On time ____ (38-42 weeks)
Late ____ How late? ____ weeks

24) How much did the baby weight at birth? _____ lbs. _____ oz. OR _____ gms

25) How long did the labor last? _____

26) The labor was: Easy ____ Moderately difficulty ____ Very difficult ____

27) What type of medication was the mother given to help with delivery? None ____
Demerol ____ Gas ____ Regional nerve (spinal) block ____ Tranquilizer ____ Epidural ____

28) Were forceps used during delivery? Yes ____ No ____

29) Was the baby born:

Head first ____ Transverse (crosswise) ____ Posterior first ____
Breech birth ____ Caesarean section ____ Vacuum extraction ____
Other: _____

30) Did the baby experience any of these problems:
 Fetal distress _____ Low placenta (Placenta previa) _____ Prolapsed cord _____
 Premature separation of the placenta (Abruptio placenta) _____

31) Describe any other special problems the mother or child had during delivery:

32) At birth, did the baby:
 Have difficulty breathing? Yes ___ No ___
 Fail to cry? Yes ___ No ___
 Appear Inactive? Yes ___ No ___

33) List the baby's Apgar scores: 1st ___ 2nd ___

34) If the father or mother noticed anything unusual when they first saw the baby, describe:

35) If the baby was born with any problems (congenital defects, large or small head, blue baby, bleeding in brain, etc.), describe: _____

36) Describe any special problems that the baby had in the first few days or weeks following birth:

37) Describe any special care, treatment, or equipment the child was given after birth:

38) How long did the baby stay in the hospital? _____

DEVELOPMENTAL HISTORY

39) For each area, indicate the child's development by circling one description. The "Average" period is only a rough idea of what is average since every developmental milestone actually involves a range of several months (e.g., walking occurs approximately 9-18 months of age). Circle "Early" or "Late" only if you are sure the child's development was different from that of most other children.

GROSS MOTOR SKILLS

Crawled	Early	Average (6-9 months)	Late
Walked alone (2-3 steps)	Early	Average (9-18 months)	Late
Pedals a tricycle	Early	Average (32-26 months)	Late

LANGUAGE

Followed simple commands	Early	Average (12-18 months)	Late
Used single-word	Early	Average (12-24 months)	Late
Said phrases	Early	Average (24-36 months)	Late
Names primary colors	Early	Average (36 to 48 months)	Late

ADAPTIVE

Toilet trained	Early	Average (13-36 months)	Late
Feeds self with spoon	Early	Average (21-24 months)	Late
Takes off open shirt/coat	Early	Average (18-24 months)	Late

40) List any other significant developmental problems:

41) Overall, the child's development was:

Early ____ Average ____ Late ____

42) As an infant or toddler, did the child have poor muscle control (i.e., weakness) of the:

Neck ____ Trunk ____ Legs ____ Arms ____

43) As an infant or toddler, did the child's muscles seem to be unusually tight or stiff?

Yes ____ No ____ If yes, describe: _____

44) Toilet training was:

Easy ____ Difficult ____

45) As an infant, to a significant degree, were any of the following present during the first two years of life?

- Did not enjoy cuddling _____
- Was not calmed by being held or stroked _____
- Difficult to comfort _____
- Colic _____
- Excessive restlessness _____
- Poor sleep _____
- Head banging _____
- Difficult nursing _____

46) Please rate the following behaviors as you child appeared during infancy and toddlerhood:

Activity Level – How active has your child been from an early age? _____

Distractibility – How well did your child pay attention? _____

Adaptability – How well did your child deal with transition and change? _____

Approach/Withdrawal – How well did your child respond to new things (i.e. people and places)? _____

Mood – What was your child's basic mood? _____

Regularity – How predictable was your child in patterns of sleep, appetite, routines, etc.? _____

HEALTH HISTORY

47) Did the child have a good appetite as a baby? Yes ____ No ____

48) Did the child fail to gain weight steadily as a baby? Yes ____ No ____

49) List the baby's illnesses or physical problems during the first year:

50) Has the child had a temperature of 104°F (40°C) or higher for more than a few hours?

Yes ___ No ___ If yes, what age(s)? _____ and how long did it last? _____

51) Has the child ever been hit hard on the head or suffered a head injury? Yes ___ No ___

If yes, what age(s)? _____ Did the child lose consciousness? Yes ___ No ___

How did it happen? _____

What problems did the child have (physical or mental) afterwards?

52) Has the child been diagnosed with seizures or epilepsy?

If yes, which type? Partial seizure ___ Generalized seizure ___ Unclassified type ___

If medication is used, what medication(s)? _____

Has the child ever had a bad reaction to this medicine? Yes ___ No ___

If yes, describe: _____

Did the child ever have a seizure due to a fever or unknown cause? Yes ___ No ___

If yes, describe (age, nature of seizure): _____

53) Was the child ever in the hospital for an accident, injury, or operation? Yes ___ No ___

If yes, what age(s)? _____ What happened? _____

54) Has the child ever swallowed any poison, non-food, or drug accidentally? Yes ___ No ___

If yes, what age(s)? _____ What happened? _____

55) Did the child have frequent ear infections? Yes ___ No ___

If yes, what age(s)? _____ How often and severe? _____

What treatment was provided? _____

56) Please check all the following diseases or conditions the child has ever had:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Mumps
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Oxygen deprivation
<input type="checkbox"/> Asthma	<input type="checkbox"/> Colds (excessive)	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver disorder	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Blood disorder	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Lung Disorder	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Brain disorder	<input type="checkbox"/> Enzyme deficiency	<input type="checkbox"/> Measles	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Broken bones	<input type="checkbox"/> Genetic disorder	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart disorder	<input type="checkbox"/> Metabolic disorder	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Eye problems	<input type="checkbox"/> Tics (eye blinking, sniffing, and repetitive movement)		
<input type="checkbox"/> Other problems	_____		

57) As the child has been growing up, he/she has been sick:

Much of the time ___ An average amount ___ Not much at all ___

58) List all the medications the child takes now:

Medication	Dosage	How often?	What for?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

59) Does the child?

Wear glasses? Yes ___ No ___ (Farsighted ___ Nearsighted ___ Other ___)
Use a hearing aid? Yes ___ No ___

60) Within the past year has the child had:

A vision test? Yes ___ No ___
A hearing test? Yes ___ No ___

RESULTS

61) What is the child's: Height: _____ ft. _____ in. Weight: _____ lbs.

62) When was the child's last medical checkup? _____

63) What therapies have been provided to the child? _____ No therapies

- _____ Occupational therapy
- _____ Physical therapy
- _____ Psychological therapy, counseling, or cognitive rehabilitation
- _____ Speech therapy
- _____ Other therapy _____

FAMILY HISTORY

64) The child lives with:

- ___ Biological parent(s) only ___ Relatives ___ Foster parents
- ___ Biological parent and other ___ Adoptive parents ___ Institutional care
- ___ Other placement _____

Please list all the people currently living in the home with the child and their relation to the child (include family and nonfamily members) _____

65) The family's income is:

under \$10,000 ___ \$10,000-29,999 ___ \$30,000-50,000 ___ over \$50,000 ___

66) What is the name of the child's biological mother? _____

a. Is she living? Yes ___ No ___ If deceased, explain: _____

b. Her age? _____

c. What is her level of education? _____

d. Her occupation? _____

If mother works outside the home, how many hours and what days _____

e. Does she live in the same house as the child? Yes ___ No ___

f. How often does she see the child? _____

g. How involved is the mother in the child's upbringing? Very ___ Somewhat ___ Not at all ___

h. During school, did the mother have:

Learning problems _____

Attention problems _____

Behavior problems _____

Medical problems _____

i. What are the mother's hobbies? _____

j. What is mother's primary language _____ Secondary language _____

- 67) What is the name of the child's biological father? _____
- a. Is he living? Yes ___ No ___ If deceased, explain: _____
 - b. His age? _____
 - c. What is his level of education? _____
 - d. His occupation? _____
If father works outside the home, how many hours and what days _____
 - e. Does he live in the same house as the child? Yes ___ No ___
 - f. How often does he see the child? _____
 - g. How involved is the father in the child's upbringing? Very ___ Somewhat ___ Not at all ___
 - h. During school, did the father have:
Learning problems _____
Attention problems _____
Behavior problems _____
Medical problems _____
 - i. What are the father's? _____
 - j. What is father's primary language _____ Secondary language _____

68) Please list the names, ages, and grade (or job) of the child's brothers and sisters:

Name	Age	Grade or job	Medical, Social, School Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

69) Has anyone in the child's biological family (including parents, grandparents, siblings, aunts, and uncles) ever had any of the following?

	Which relative?	Describe the problem briefly
___ Brain disease	_____	_____
___ Developmental Delay	_____	_____
___ Epilepsy or seizures	_____	_____
___ Learning disability	_____	_____
___ Mental retardation	_____	_____
___ Neurologic disease	_____	_____
___ Psychological problems	_____	_____
___ Reading/spelling difficulties	_____	_____
___ Speech/language problems	_____	_____

70) Which of the child's biological relatives are left-handed? No one _____
Mother ___ Father ___ Sibling(s) ___ Grandparents ___

71) What languages are spoken in the home? (List in order of most frequent first)
(1) _____ (2) _____

72) How is the child disciplined? _____

Is the discipline effective? _____

73) List the child's usual recreational activities and hobbies: _____

74) Have there been any major family stresses or changes in the past year (e.g., moving with change of school, divorce, significant illness, etc.)? Yes ___ No ___
If yes, explain: _____

How much stress has these changes caused the child? (circle one)
None Mild Moderate Severe

75) Does the child attend day care outside the home or does someone come into the home to provide the service? _____
Does day care provide any type of formal program of play, developmental, or academic activities? _____

PEER RELATIONSHIPS

76) Does your child seek friendships with peers? _____

77) Is your child sought by peers for friendship? _____

78) Does your child play with children primarily his or her own age ? _____
Younger? _____ Older? _____
79) Describe any problems your child may have with peers _____

SCHOOL HISTORY

80) The child's present school is: Name _____
Address _____
Phone _____ Contact person _____

81) Was the child ever held back to repeat a grade? Yes ___ No ___
If yes, which grade? _____ Why? _____

82) Has the child ever been in a special class or provided with special services (e.g., RSP, Self-contained day class, learning or language disability class, etc.) Yes ___ No ___
If yes, describe the special class _____

Is the child in this class or receiving special services now? Yes ___ No ___
If yes, describe the present class placement _____

83) Does the child like school? Most of the time ___ Sometimes ___ Almost never ___

84) Does the child:

- | | | |
|--|---------|--------|
| Have problems with other children in class? | Yes ___ | No ___ |
| Have problems making friends in school? | Yes ___ | No ___ |
| Have problems getting along with teachers? | Yes ___ | No ___ |
| Tend to get sick in the morning before school? | Yes ___ | No ___ |

85) Describe the teacher's concerns about the child's schoolwork or behavior:

86) What kind of grades has the child received in the past year?

A's & B's ___ B's & C's ___ C's & D's ___ D's & F's ___

Or

Outstanding ___ Good ___ Satisfactory ___ Improvement needed ___ Unsatisfactory ___

Or

Other grading system _____

Are these grades a change from previous years? Yes ___ No ___

If yes, describe _____

87) In which subject(s) does the child do best? _____

88) Which subject(s) are the most difficult? _____

89) In the past year, how much school has the child missed due to illness or injury?

Less than 2 weeks ___ 2-4 weeks ___ 5-8 weeks ___ Over 8 weeks ___

Briefly describe the reasons if the child has missed a lot of school:

90) Does the child seem to have a "school phobia?"

Yes ___ No ___

If yes, explain: _____

91) Do you consider your child to understand directions and situations as well as other children his or her age? _____

92) How would you rate your child's overall intelligence compared to other children?

Below average _____ Above average _____ Average _____

PREVIOUS EVALUATIONS

93) Which of these tests or procedures has recently has been done? Note if normal or abnormal

Evaluation	Normal	Abnormal	Date
___ Blood work	_____	_____	_____
___ Family physician or pediatrician office visit	_____	_____	_____

<input type="checkbox"/> Hearing testing	_____	_____	_____
<input type="checkbox"/> Lead level check	_____	_____	_____
<input type="checkbox"/> Lumbar puncture or spinal tap	_____	_____	_____
<input type="checkbox"/> Neurological examination or testing (CT scan, EEG)	_____	_____	_____
<input type="checkbox"/> Psychological or Neuropsychological testing	_____	_____	_____
<input type="checkbox"/> School testing	_____	_____	_____
<input type="checkbox"/> Speech & Language testing	_____	_____	_____
<input type="checkbox"/> Vision testing	_____	_____	_____
<input type="checkbox"/> X-rays	_____	_____	_____
<input type="checkbox"/> Other tests:	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

94) What are the names of the physician, psychologist, school authority, or other professionals who are most familiar with the child's problems?

Name _____
 Address _____

 Phone _____
 Profession _____

Name _____
 Address _____

 Phone _____
 Profession _____

Please Note: If your child has seen a psychologist at any time in the last year for testing or treatment, please be sure to advise the doctor.

ADDITIONAL COMMENTS: Please note below any further information you feel may be helpful in the evaluation of your child

 Parent or Guardian's Signature

 Date

THANK YOU FOR TAKING THE TIME TO CAREFULLY COMPLETE THIS QUESTIONNAIRE.