

# CHILD NEUROPSYCHOLOGY QUESTIONNAIRE

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*Please fill out the following questionnaire as best as you can.*

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

Date of Evaluation: \_\_\_\_\_

Person who referred you for evaluation: \_\_\_\_\_

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

## **Referral Information:**

What is the reason the child/adolescent is being evaluated? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

## **Family Information:**

Address \_\_\_\_\_

Telephone/e-mail address \_\_\_\_\_

Name of Parents

Mother \_\_\_\_\_ age: \_\_\_\_\_ education: \_\_\_\_\_

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

Occupation \_\_\_\_\_

Father \_\_\_\_\_ age: \_\_\_\_\_ education: \_\_\_\_\_

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

Occupation \_\_\_\_\_

Parents are: married \_\_\_\_\_ separated \_\_\_\_\_ divorced \_\_\_\_\_ (Custody is with \_\_\_\_\_)

Re-married \_\_\_\_\_ deceased \_\_\_\_\_

Child is: biological \_\_\_\_\_ adopted (at age \_\_\_\_\_) foster \_\_\_\_\_

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

Who lives in the home? \_\_\_\_\_  
\_\_\_\_\_

**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?) \_\_\_\_\_  
smoking? \_\_\_\_\_ alcohol? \_\_\_\_\_ illicit drugs? \_\_\_\_\_ antibiotics? \_\_\_\_\_  
depression or other emotional problems? \_\_\_\_\_ blood incompatibility? \_\_\_\_\_ injury? \_\_\_\_\_ other? \_\_\_\_\_

List any medications, tobacco use, alcohol use, or drugs taken by mother during pregnancy \_\_\_\_\_  
\_\_\_\_\_

Delivery was vaginal \_\_\_\_\_ Cesarean \_\_\_\_\_ (reason \_\_\_\_\_)  
Baby was full term \_\_\_\_\_ or premature \_\_\_\_\_ (\_\_\_\_\_ weeks gestation)  
Birth Weight \_\_\_\_\_ lbs. \_\_\_\_\_ ozs.  
Was labor prolonged? \_\_\_\_\_ (length of time = \_\_\_\_\_)  
Any birth complications? (e.g., feet first/cord around neck/meconium staining/lacking oxygen-  
blue/jaundice-yellow) \_\_\_\_\_  
Did baby breathe spontaneously? \_\_\_\_\_ oxygen required? \_\_\_\_\_  
Apgar scores if known \_\_\_\_\_ In Intensive Care Nursery? \_\_\_\_\_  
How old was baby at discharge from the hospital after birth? \_\_\_\_\_  
Medical problems after discharge (e.g., jaundice, fever, transfusion, surgery) \_\_\_\_\_  
\_\_\_\_\_

Any problem in first few months? \_\_\_\_\_

**Developmental History:**

Motor:

Age sat alone \_\_\_\_\_ crawled \_\_\_\_\_ stood alone \_\_\_\_\_ 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)? \_\_\_\_\_

Was physical therapy ever necessary? (when?) \_\_\_\_\_

Was occupational therapy ever necessary? (when?) \_\_\_\_\_

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 speech/language therapy ever necessary (when)? \_\_\_\_\_

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

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

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

Toileting:

Age when toilet trained \_\_\_\_\_

Problems with bedwetting?, urine accidents?, soiling?, Until what age? \_\_\_\_\_

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

Social Behavior:

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?) \_\_\_\_\_

Have problems with peer pressure? (e.g., alcohol or drug use) \_\_\_\_\_

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

\_\_\_\_\_

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**Medical History:**

Has vision been checked? \_\_\_\_\_ If yes, when? \_\_\_\_\_ Any problems? \_\_\_\_\_

Has hearing been checked? \_\_\_\_\_ If yes, when? \_\_\_\_\_ Any problems? \_\_\_\_\_

Has your child ever received a CT \_\_\_\_\_ MRI \_\_\_\_\_ EEG \_\_\_\_\_ If so, when? \_\_\_\_\_

Do you know the results \_\_\_\_\_

Other tests and results: \_\_\_\_\_

List serious illnesses/injuries/hospitalizations/surgeries

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

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

Failure-to-thrive? \_\_\_\_\_

Febrile seizures? (fever associated) \_\_\_\_\_

Epilepsy? \_\_\_\_\_

Staring spells? \_\_\_\_\_

Lead poisoning/toxic ingestion? \_\_\_\_\_

Meningitis or encephalitis? \_\_\_\_\_

Asthma or allergies? \_\_\_\_\_

Diabetes? \_\_\_\_\_

Loss of consciousness? \_\_\_\_\_

Abdominal pains/vomiting? \_\_\_\_\_

When do they occur? \_\_\_\_\_

Headaches? \_\_\_\_\_

When do they occur? \_\_\_\_\_

Frequent ear infections? \_\_\_\_\_

Were ear tubes necessary? \_\_\_\_\_

Age when tubes placed: \_\_\_\_\_

Sleep difficulties? \_\_\_\_\_

Sleep walking/talking: \_\_\_\_\_

Eating difficulties or eating disorder \_\_\_\_\_

Tics/twitching? \_\_\_\_\_

Repetitive/stereotypic movements

(e.g., hand flapping)? \_\_\_\_\_

Impulsivity? \_\_\_\_\_

Temper tantrums? \_\_\_\_\_

Nail biting? \_\_\_\_\_

Clumsiness? \_\_\_\_\_

Head banging? \_\_\_\_\_

Self-injurious behavior? \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current medications and reasons:\_\_\_\_\_

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

Is there a history of neurological illness in any family member?\_\_\_\_\_

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

Is there a family history of psychiatric disorders?\_\_\_\_\_

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

**Educational History:**

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

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

Other\_\_\_\_\_

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

Teachers report problems in:

Reading	_____	Attention/concentration	_____
Spelling	_____	Behavior	_____
Arithmetic	_____	Social adjustment	_____
Writing	_____		

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

\_\_\_\_\_

Grade: \_\_\_\_\_ Academic problems? (please describe)

Nursery

Kindergarten

First

Second

Third

Fourth

Fifth

Sixth

Seventh

Eighth

Ninth

Tenth

Eleventh

Twelfth

Is your child unusually hyperactive? \_\_\_\_\_ impulsive? \_\_\_\_\_

Inattentive? \_\_\_\_\_

Specific problems noted: \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

**Prior Psychological History:**

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

Name of professional	Address	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 of the professional who evaluated your child? \_\_\_\_\_

Please describe any cognitive/thinking difficulties your child is experiencing (e.g., memory, concentration, organizational skills, language, problem-solving, etc).

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