Comprehensive
Neuropsychology
Services, PLLC

Child's Name (list preferred name here, if applicable):____

Date of Birth: ____________________________ Current Age:________________________________

The information you share is confidential and privileged. Please answer questions as best you can.

Patient History Form

Identifying Information	
Sex	Sex at birth: ☐ Male ☐ Female
Today's Date:	_____/_____/_____
Person Completing This Form:	Your name: ___________________________ Relationship to child: _____________________ Do you have legal custody? ☐ Yes ☐ No
Contact Information	Primary Address: ____ ____ Phone: ___________________________ Other phone: ____________________ Email: ____________________________ Other email: ____________________
Who referred you for this evaluation?	☐ Self ☐ Other: ____
What are your main concerns?	
What questions do you hope this evaluation will address?	
What strategies or supports have you tried to help?	
Has your child ever undergone any of the following evaluations? (if yes, please provide date)	☐ Neuropsychological evaluation: ______________________________________ ☐ Psychoeducational/school-based evaluation/IEP testing: ____________________ ☐ Psychological evaluation: ____ ☐ Psychiatric evaluation:____ ☐ Speech and language/occupational therapy evaluation: ____________________ *PLEASE SEND COPIES OF ALL PRIOR EVALUATIONS* Email: baum@comprehensiveneuropsychologyservices.com

Has your child been diagnosed with any of the following? If yes, please describe.	☐ Learning problems (e.g., reading, math, writing, etc.)	
	☐ Developmental disorders (e.g., ADHD, autism, intellectual disability, developmental delay, etc.)	
	☐ Mental health concerns (e.g., depression, anxiety, bipolar disorder, etc.)	
What are the best things about your child – his or her strengths and/or accomplishments?		

Family Information

Information on Parents/Guardians involved in child's care: Name: ______________________ Relationship:_________________ Example: Biological mother (or father), adoptive mother, step-parent, grandparent, etc. Name: ______________________ Relationship: _________________	Age: ______ Education: ________________ Occupation: _________________ Work Title: ____________________ Employer: _____________________ Age: ______ Education: ________________ Occupation: ________________ Work Title: ____________________ Employer: _____________________
Information on biological parents if they are NOT listed above (if known): ☐ N/A	Biological Mother: Age: ______ Education: ________________ Occupation: ___________________ Biological Father: Age: ______ Education: ________________ Occupation: ___________________
My Child Is:	☐ Biological ☐ Adopted ☐ Foster ☐ Other
The Child's Parents Are:	☐ Married ☐ Divorced ☐ Separated ☐ Never Married If separated or divorced, when:____
Please list all brothers and sisters, including full, half and step-siblings.	<u>Name</u> <u>Age</u> <u>Living with the child now?</u> ____________________ ____ ☐ Yes ☐ No ____________________ ____ ☐ Yes ☐ No ____________________ ____ ☐ Yes ☐ No ____________________ ____ ☐ Yes ☐ No ____________________ ____ ☐ Yes ☐ No ____________________ ____ ☐ Yes ☐ No

Please list anyone else living in the child's home, and indicate their relationship to the child.	
Does your child routinely live in more than one home? If so, please describe:	
Is English your child's primary language?	☐ No ☐ Yes
Any language other than English spoken at home?	☐ No ☐ Yes (please identify: ________________________)
Do any of your immediate (imm.) or extended (ext.) family members have a history of the following? Please check all that apply.	Name / Imm. / Ext. — ADD/ADHD ☐ ☐; Attention problems ☐ ☐; Autism spectrum ☐ ☐; Developmental delay ☐ ☐; Intellectual disability ☐ ☐; Learning problems ☐ ☐; -Reading problems ☐ ☐; -Math problems ☐ ☐; -Writing problems ☐ ☐; Behavior problems ☐ ☐ Name / Imm. / Ext. — Anxiety/OCD ☐ ☐; Depression ☐ ☐; Bipolar disorder ☐ ☐; Schizophrenia ☐ ☐; Oppositional/defiance ☐ ☐; Behavior problems ☐ ☐; Alcohol/drug abuse ☐ ☐; Tics/Tourettes ☐ ☐; Seizures/Epilepsy ☐ ☐; Migraine/headaches ☐ ☐ Other (please describe):
Any major stressors or changes that may have affected your child's development (e.g., deaths, moves, divorces, loss of job)	☐ No ☐ Yes (please describe and indicate when)
Are there special considerations that you want us to be aware of related to your cultural, spiritual or religious needs?	☐ No ☐ Yes (please describe below)

Pregnancy and Birth History

Did the child's biological mother have any health problems during her pregnancy with the child?	☐ No ☐ Yes (please describe):
During the pregnancy, did the biological mother?	Take medications? (List:__________________________) ☐ Yes ☐ No Drink alcohol? ☐ Yes ☐ No Smoke tobacco? ☐ Yes ☐ No Use Drugs (specify): ☐ Yes ☐ No Experience extreme stress/ injury (describe): ☐ Yes ☐ No
The baby was born:	☐ Premature (_____ weeks) ☐ Full Term (37+ weeks) ☐ Late Term (40+ weeks) Birth Weight: ___ lbs. ___oz
How was the child born?	☐ Vaginal Delivery ☐ Cesarean Section
Were there any delivery complications or birth defects noted?	☐ No ☐ Yes (please describe):

Apgar Scores (if known):	One Minute __________ Five Minutes __________
How soon after birth was the baby discharged from the hospital?	
Any problems in the first year of life?	☐ No ☐ Yes (please describe):
Did the baby have to return to the hospital during his/her first year of life?	☐ No ☐ Yes (please describe):

Developmental History

Motor					
At what age did the child:	Sit Up: ☐ Early	☐ Average (5-7 months)	☐ Late	☐ Not Yet	
	Crawl: ☐ Early	☐ Average (8-10 months)	☐ Late	☐ Not Yet	
	Walk: ☐ Early	☐ Average (11-13 months)	☐ Late	☐ Not Yet	
Was the child slow to develop motor skills or awkward in comparison to peers/siblings?	☐ No ☐ Yes (please describe):				
Handedness:	☐ Right ☐ Left ☐ Both Is there a family history of left-handedness? ☐ No ☐ Yes				

Language					
At what age did the child:	Say "dada"/ "mama":	☐ Early	☐ Average (11-14 months)	☐ Late	☐ Not Yet
	Say other single words:	☐ Early	☐ Average (12-14 months)	☐ Late	☐ Not Yet
	Put 2-3 words together:	☐ Early	☐ Average (20-24 months)	☐ Late	☐ Not Yet
Any history of speech delays or problems (e.g., difficult to understand, stuttering)?	☐ No ☐ Yes (please describe):				

Adaptive	
When was the child toilet-trained (daytime)?	For Urination: ________ For Bowel Movements: _________
Any problems with bed wetting, daytime urine accidents, or soiling?	☐ No ☐ Yes (please describe):
Feeding, Appetite or Growth Concerns?	☐ No ☐ Yes (please describe):

Social/Emotional History and Functioning

Describe your child socially (friends, fights, dating, popularity, participation, etc.)	

Which of the following describes your child in social interactions with peers (i.e., not siblings) :	☐ Often prefers to play alone ☐ Hesitant to join in play, or only engages in parallel play (i.e., plays alongside independently) with other children ☐ Prefers to play with younger children ☐ Has had problems relating to playmates, classmates, or peers ☐ Has/had difficulty making or keeping friends ☐ Does not have opportunity to play with children outside of family
Are there behavioral concerns at home or school (e.g., temper tantrums, hyperactivity, impulsivity, aggression)?	☐ No ☐ Yes (please describe):
Are there concerns with inattention, difficulty focusing or spacing out?	☐ No ☐ Yes (please describe):
Have you noticed any repetitive behaviors (e.g., flapping hands) or sensory to lights/sounds/textures?	☐ No ☐ Yes (please describe):
What activities does your child enjoy or participate in (interests, hobbies, sports, or clubs/groups)?	

Services

Has your child ever lost developmental skills (e.g., regressed) in any area?	☐ No ☐ Yes (please describe):

Does your child receive any of the following services? Please check all that apply.

Service	Currently	In the past
Speech/language therapy	☐	☐
Occupational therapy	☐	☐
Physical therapy	☐	☐
Feeding therapy	☐	☐
Behavioral / psychological therapy	☐	☐
Other (name):	☐	☐

Medical History

List any hospitalizations, procedures or surgeries and years/ages	
Has your child sustained any head injuries or concussions?	☐ No ☐ Yes (give date, describe what happened, changes in behavior after):

Are you concerned about your child's:	Appetite ☐ No ☐ Yes (describe): Weight ☐ No ☐ Yes (describe): Vision ☐ No ☐ Yes (describe): Hearing ☐ No ☐ Yes (describe): Sleep ☐ No ☐ Yes (describe):
Does your child participate in regular exercise/physical activity?	☐ No ☐ Yes (please describe):
Has your child <u>had</u> any medical problems?	☐ No ☐ Yes (please describe):
Does your child <u>currently have</u> any medical problems?	☐ No ☐ Yes (please describe):
Does your child experience recurrent pain? If so, please indicate which type.	Stomachaches ☐ No ☐ Yes (describe): Headaches/migraines ☐ No ☐ Yes (describe): Body aches (e.g., joint pain) ☐ No ☐ Yes (describe):
Do you know or suspect that your child has used or is currently using any of the following:	Alcohol ☐ No ☐ Yes Tobacco ☐ No ☐ Yes Illicit drugs (e.g., marijuana, cocaine) ☐ No ☐ Yes Drugs not prescribed to them ☐ No ☐ Yes
Current medications/supplements, dosage, and reason, if applicable:	If applicable, please complete the list below. Attach an additional page if needed. *Name of Drug* *Reason for Drug* *Who Prescribed* _____________ _____________ _____________ _____________ _____________ _____________ _____________ _____________ _____________ _____________ _____________ _____________ _____________ _____________ _____________
Does your child have any known allergies?	If yes, please describe

Educational History

Name, address & phone number of child's current school:	School's Name:______________________________ ☐ Public ☐ Private ☐ Charter School District: ______________________________ School Phone: (_______) _________ - ___________ City: ______________________ State: _____

Please provide the names and grades of attendance for all schools at which your child has been enrolled.	School: ___________________________ For Grades: ___________ School: ___________________________ For Grades: ___________ School: ___________________________ For Grades: ___________
Any grades repeated or skipped?	☐ No ☐ Yes (please describe):
Does your child have any of the following supports at school?	*PLEASE SEND IN COPY OF CURRENT IEP/504/IFSP (IF APPLICABLE)* ☐ IEP ☐ Section 504 Plan ☐ Other: _________________ ☐ IFSP ☐ Behavioral Plan *If your child does have supports*: When did it start?_____________________________ What classification (if known)?_____________________________________
Child's current grade in school:	
Does your child receive any of the following services at school?	☐ Learning support in reading/math/writing ☐ Resource Room ☐ Behavioral supports ☐ Life skills ☐ Vocational training ☐ Gifted and Talented ☐ Other: ____
Describe your child's academic abilities and interests	Academic strengths/favorite subject(s):____________________________________ Academic weaknesses/least favorite subject(s):______________________________ Typical/current grades:____ ____
My child's intelligence is likely:	☐ Below Average ☐ Average ☐ Above Average ☐ Superior

Legal Status

Has your child had any problem with police or other law enforcement?	☐ No ☐ Yes (please describe):
Are you working with an attorney or is there any court action planned or underway concerning your child?	☐ No ☐ Yes (please describe):

Safety Screening

Do you think or know that your child has been physically abused?	☐ No	☐ Yes
Do you think or know that your child has been emotionally abused?	☐ No	☐ Yes
Do you think or know that your child has been sexually abused?	☐ No	☐ Yes
Has your child experienced any other known trauma, abuse, or neglect?	☐ No	☐ Yes

Has your child ever hurt another person in a physical, emotional or sexual way?	☐ No	☐ Yes
Has your child ever abused a pet or another animal?	☐ No	☐ Yes
Has your child ever talked about deliberately hurting him/herself?	☐ No	☐ Yes
Has your child ever engaged in self-injurious behavior?	☐ No	☐ Yes
Has your child known someone who attempted or completed suicide?	☐ No	☐ Yes
Is there a gun in your child's home or do they have access to a firearm?	☐ No	☐ Yes

Additional Comments

Please use the space below to note any additional information you consider important.

I appreciate your time in completing this form. The information you provided will be useful in caring for your child.

Send relevant evaluation reports, education plans, grades, test scores, etc. to baum@comprehensiveneuropsychologyservices.com.