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**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 XGender: Male Female Other :\_\_\_\_\_\_\_\_\_\_ XX |
| 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.  |

|  |  |  |
| --- | --- | --- |
| Name | Age | Living with the child now?  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ |  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. | Name | Imm. | Ext. |
| ADD/ADHD |  |  | Anxiety/OCD |  |  |
| Attention problems |  |  | Depression |  |  |
| Autism spectrum |  |  | Bipolar disorder |  |  |
| Developmental delay |  |  | Schizophrenia |  |  |
| Intellectual disability |  |  | Oppositional/defiance |  |  |
| Learning problems |  |  | Behavior problems |  |  |
|  -Reading problems |  |  | Alcohol/drug abuse |  |  |
|  -Math problems |  |  | Tics/Tourettes |  |  |
|  -Writing problems |  |  | Seizures/Epilepsy |  |  |
| Behavior problems |  |  | 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? Did the baby have to return to the hospital during his/her first year of life?   |  |  No Yes (please describe): 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 aloneHesitant to join in play, or only engages in parallel play (i.e., plays alongside independently)with other children Prefers to play with younger childrenHas had problems relating to playmates, classmates, or peersHas/had difficulty making or keeping friendsDoes 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 had any medical problems? |

|  |  |
| --- | --- |
|  No |  Yes (please describe): |

 |
| Does your child currently have 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 CharterSchool 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.