NORTHEAST NEUROPSYCHOLOGY
BRAIN & BEHAVIORAL HEALTH PARTNERS

CHILD
History
Report Form

Please bring the most recent psychoeducational evaluations and/or IEP if applicable. (From school or any other source).

Please fill this out to your best of your ability and bring the completed form to your child's appointment.

Name **Date of Birth**

Address **Phone**

School **Grade**

Handedness: ❑ Right ❑Left ❑ Ambidextrous

Birth Sex ❑ M ❑ F ❑ Unidentified Gender Identity: _____ Preferred Pronouns _____

Reason(s) you are requesting this evaluation:

PREGNANCY AND BIRTH HISTORY

Age of mother at delivery: _____

Were there problems becoming pregnant?❑ Yes ❑ No

Did mother receive regular prenatal care?❑ Yes ❑ No

If YES to above, please explain:

Mother's health during pregnancy *(check all that apply. If any apply, please, explain on next page):*

❑ Toxemia ❑RH Incompatibility ❑High blood pressure ❑Fevers ❑Diabetes ❑Epilepsy

❑ Injuries❑Medications❑ Drank alcohol ❑ Smoked cigarettes ❑ Used recreational drugs

❑Other _____

If yes to above, please explain: _____

Delivery was: ❑ Full term ❑ Premature (_____ weeks of gestation)

Delivery was: ❑ Vaginal ❑ Cesarean Birth weight _____ lbs _____ oz

Condition at birth: ❑ Healthy ❑ Problems *If problems occurred, please explain: :*

DEVELOPMENTAL HISTORY

As a young child my child was:

❑ **Cuddly** ❑ **Social** ❑ **Difficult to soothe** ❑ **Fussy** ❑ **Quiet** ❑**Slow to adjust to change**

Motor Milestones: Age sat alone _____ Crawled _____ Walked alone _____

Language: Age first word spoken _____ Put 2 words together _____ Put 3 words together _____

Toilet training: Age training was initiated:Bowel _____ Bladder _____

Age training was completed: Bowel _____ Bladder _____

Eating difficulties: ❑ **Yes** ❑ **No** *(if YES, please explain)*

_____

Sleeping difficulties: ❑ **Yes** ❑ **No** *(if YES, please explain)*

_____

Problems with separation from parents: ❑ **Yes** ❑ **No** *(if YES, please explain)*

_____

Behavior problems: ❑ **Yes** ❑ **No** *(if YES, please explain)*

_____

Did your child receive Birth-To-Three Services? ❑ **Yes** ❑ **No** *(if YES, please check all that apply and explain)*

❑ Occupational Therapy ❑Physical Therapy ❑Speech Therapy

_____
_____
_____

Other:_____
_____
_____
_____
_____
_____
_____
_____

MEDICAL / HEALTH HISTORY

Physician name: _____ Phone number: _____

Address: _____

Is your pediatrician aware of this referral? ❑ **Yes** ❑ **No**

Has vision been checked? ❑ **Yes** ❑ **No** (date) _____Any problems? _____

Has hearing been checked. ❑ **Yes** ❑ **No** (date) _____Any problems? _____

List all serious illnesses/injuries/hospitalizations/surgeries:

DATE	**Hospital Name/Location**	**Reason Hospitalized**

MEDICATION - please list all current and past medications:

Type	**Dose**	**Start Date**	**End Date**	**Prescribing Physician**	**Physician's Phone #**

Please bring your child's medication list to their appointment if it is longer than can fit on this form.
You may also use page 9 to add medication or other notes relevant to your child.

Is there a history of any of the following conditions? Please note if your child has any of these conditions/illnesses listed below and the date you were diagnosed. Provide details about the conditions/illness on the line provided or on a separate sheet. *(please check any that are applicable)*

- ❑ **Febrile seizure**
- ❑ **Epilepsy**
- ❑ **Lead poisoning/toxic ingestion**
- ❑ **Asthma or allergies**
- ❑ **Head injury**
- ❑ **Loss of consciousness**
- ❑ **Abdominal pain/vomiting**
  When do they occur?_____
- ❑ **Headaches**
  When do they occur? _____
- ❑ **Frequent ear infections**
- ❑ **Sleeping difficulties**
- ❑ **Eating difficulties**
- ❑ **Tics/twitching**
- ❑ **Cardiac problems**
- ❑ **Pulmonary problems**
- ❑ **Kidney problems**
- ❑ **Liver problems**
- ❑ **Diabetes**
- ❑ **Orthopedic problems**
- ❑ **Pain problems**
- ❑ **Stomach problems**
- ❑ **Exposure to toxins**
- ❑ **Endocrine problems**
- ❑ **Blood disorder**
- ❑ **Other problems**

SENSORY / MOTOR / NON VERBAL

Does your child…

Dislike certain food textures? ❑ **Yes** ❑ **No**

Chew on non-food items? (e.g. shirt, pencils)

❑ **Yes** ❑ **No**

Dislike touching certain textures? (e.g. paste)

❑ **Yes** ❑ **No**

Dislike getting dirty? ❑ **Yes** ❑ **No**

Dislike being touched? ❑ **Yes** ❑ **No**

Have repetitive movements? ❑ **Yes** ❑ **No**

Have unusual voice patterns? ❑ **Yes** ❑ **No**

Appear clumsy or off-balance? ❑ **Yes** ❑ **No**

Have trouble with hand-eye coordination?

❑ **Yes** ❑ **No**

Have an unusual posture/gait? ❑ **Yes** ❑ **No**

Have difficulty with coordination? ❑ **Yes** ❑ **No**

Have difficulty with geographic directions?

❑ **Yes** ❑ **No**

Have difficulty telling left from right? ❑ **Yes** ❑ **No**

Have difficulty learning about maps or graphs?

❑ **Yes** ❑ **No**

Have difficulty interpreting social cues? ❑ **Yes** ❑ **No**

Have difficulty putting self in others' shoes?

❑ **Yes** ❑ **No**

Have difficulty understanding aspects of humor?

❑ **Yes** ❑ **No**

Please feel free to explain any of the above behaviors further:

BEHAVIORAL HEALTH

Is there any significant history of the following behaviors? (please check yes or no)

Irritability ❑ **Yes** ❑ **No**

Poor eye contact ❑ **Yes** ❑ **No**

Unhappy ❑ **Yes** ❑ **No**

Dependent ❑ **Yes** ❑ **No**

Sadness or depression ❑ **Yes** ❑ **No**

Isolating socially ❑ **Yes** ❑ **No**

Lack of enjoyment with activities ❑ **Yes** ❑ **No**

Feeling tense or anxious ❑ **Yes** ❑ **No**

Biting nails ❑ **Yes** ❑ **No**

Trouble with changes to routine ❑ **Yes** ❑ **No**

Obsessive or Compulsive behaviors ❑ **Yes** ❑ **No**

Overly timid or scared ❑ **Yes** ❑ **No**

Traumatized ❑ **Yes** ❑ **No**

Nightmares ❑ **Yes** ❑ **No**

Shyness ❑ **Yes** ❑ **No**

Demonstrating verbal aggression ❑ **Yes** ❑ **No**

Demonstrating physical aggression ❑ **Yes** ❑ **No**

Problems playing with others ❑ **Yes** ❑ **No**

Disruptive ❑ **Yes** ❑ **No**

Short tempered ❑ **Yes** ❑ **No**

Trouble following rules ❑ **Yes** ❑ **No**

Difficulty with authority ❑ **Yes** ❑ **No**

Distractible ❑ **Yes** ❑ **No**

Memory problems/forgetful ❑ **Yes** ❑ **No**

Difficulty with problem solving ❑ **Yes** ❑ **No**

Disorganized ❑ **Yes** ❑ **No**

Problems with attention ❑ **Yes** ❑ **No**

Impulsive ❑ **Yes** ❑ **No**

Difficulty setting and reaching goals ❑ **Yes** ❑ **No**

Trouble sequencing ❑ **Yes** ❑ **No**

Trouble following directions ❑ **Yes** ❑ **No**

Other info about behaviors you would like to add? Please add any relevant information here:

_____
_____
_____
_____
_____
_____
_____
_____
_____

HISTORY OF TREATMENT: Therapies/Evaluations

	Psychology/Psychiatry	Occupational Therapy	Physical Therapy	Speech/Language
Evaluation				
Date(s)				
Provider				
Treatment				
Date(s)				
Provider				

HISTORY OF TREATMENT: Therapies/Evaluations *continued*

Does your child receive special services at school? ❑ **Yes** ❑ **No** 504 or IEP; Exceptionality_____

Current medical diagnoses: ❑ **Yes** ❑ **No** _____

Current psychiatric diagnoses: ❑ **Yes** ❑ **No** _____

Current speech diagnoses: ❑ **Yes** ❑ **No** _____

Add any additional relevant information here.

_____

_____

EDUCATIONAL HISTORY

Skipped or repeated a grade: ❑ **Yes** ❑ **No**

Teacher report problems in: ❑**Reading** ❑**Spelling** ❑**Math** ❑**Writing**

Please explain:

_____

_____

_____

_____

Grade **Academic Problems or Behavioral Problems in School ?** *(if applicable, please explain)*

Pre-school _____

Kindergarten_____

First _____

Second _____

Third _____

Fourth _____

Fifth _____

Sixth _____

Seventh _____

Eighth _____

Ninth _____

Tenth _____

Eleventh _____

Twelfth _____

FAMILY / SOCIAL HISTORY

Father's Information

Name _____
Occupation _____
Education _____
Overall Health _____

Mother's Information

Name _____
Occupation _____
Education _____
Overall Health _____

This is your: ❑ Biological child ❑ Adopted child ❑ Foster child ❑ You have guardianship of this child

Parents are ❑Unmarried ❑Married ❑Separated ❑Divorced ❑Widowed/Widower

Are there significant family or marital conflicts? ❑ **Yes** ❑ **No**

_____

Name of the child's legal guardian(s): _____

Please list all immediate family members who reside with the child:

Full Name	**Sex**	**Date of Birth**	**Age**	**Grade**	**Relationship**

My child plays with children their own age: ❑ **Yes** ❑ **No**

My child engages in normal imaginative or pretend play: ❑ **Yes** ❑ **No**

My child's play generally revolves around one particular theme with minimal variation: ❑ **Yes** ❑ **No**

My child is willing to let others join in games and play situations: ❑ **Yes** ❑ **No**

My child engages in parallel play (plays besides another but does not engage them): ❑ **Yes** ❑ **No**

My child engages in cooperative play: ❑ **Yes** ❑ **No**

My child gets along well with other children: ❑ **Yes** ❑ **No**

What does your child enjoy doing? _____

Please specify if any of the following events occurred during the previous 2 years:

Deaths _____

Move _____

Job transfer _____

Accidents/serious illnesses _____

FAMILY / SOCIAL HISTORY *continued*

Please provide a family history. Include the child's parents, grandparents, siblings, aunts, uncles, and cousins.

Please note the relationship to child:

Is there a history of…	**Mother's Side**	**Father's Side**
Learning problems?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Reading problems?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Attention problems?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Stuttering?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Epilepsy or seizures?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Other neurologic disorders?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Diabetes?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Genetic or inherited disorders?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Other serious illnesses/health problems?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Emotional disorders?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Received/is receiving psychiatric treatment?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Hospitalized for an emotional problem?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Drug/alcohol addiction/misuse?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Attempted/committed suicide?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
Violent behavior?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**

Signature

_____

Relationship to child _____

Date Completed _____

Need Extra Space?

Please use this page to add any relevant information you could not fit on the other pages.