SOUTHWEST
NEUROPSYCHOLOGY
SERVICES

1515 E Missouri Ave Ste 111 • Phoenix, AZ 85014

CHILDREN'S HISTORY FORM

Please complete this form to the best of your knowledge and return it to us before your child's appointment. Some questions may not be applicable to your child. If you need more space or wish to make any additional comments, please attach a separate sheet.

Name of person filling out this form: Date: _____

Relationship to child: _____

Child's Name: _____

Sex: _____ Age: _____ Birth Date: _____

School: _____ Grade: _____

Pediatrician: _____ Phone: _____

If you would like a copy of the report to go to your child's pediatrician, please list the doctor's address here:

_____

_____

Referred by: _____

Reason(s) for consultation or evaluation: (What questions do you want answered?)

_____

_____

_____

Has your child had previous evaluations? (Psychological, psychoeducational, or neuropsychological either at school or privately) ☐ Yes ☐ No

If yes, when and by whom? _____

If you have copies of these reports (or any other pertinent records) please fax them to us before your child's appointment.

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FAMILY HISTORY

Relationship	Name	Age	Occupation	Education/Grade
Father				
Step-Father				
Mother				
Step-Mother				
Child				
Child				
Child				
Child				

Are there significant conflicts…

Between parents? ☐ Yes ☐ No

Between parent and child? ☐ Yes ☐ No

Between children? ☐ Yes ☐ No

Do parents agree on how to discipline your child? ☐ Yes ☐ No

Who disciplines, and how? _____

_____

How does your child respond to discipline? _____

_____

PREGNANCY

Is this child adopted? ☐ Yes ☐ No

If yes, at what age was your child adopted? _____

Were there any of the following complications during this pregnancy? (If so, indicate the month)

☐ Anemia	☐ Bleeding	☐ German measles
☐ Swollen ankles	☐ Virus	☐ Vomiting
☐ Heart disease	☐ High blood pressure	☐ Threatened miscarriage
☐ Toxemia	☐ Kidney disease	☐ Early contractions
☐ Drug Use	☐ Alcohol Use	☐ Smoking
☐ Anxiety	☐ Depression	☐ Early contractions

Other: _____

List any of the following experienced during this pregnancy:

Chronic illnesses (e.g. diabetes, kidney infection, thyroid, etc.) _____

Other illnesses: _____

Hospitalizations (date & reason): _____

Surgeries: _____

Injuries: _____

Medications taken: _____

BIRTH HISTORY

Hospital name: _____ Hours from first contraction to birth: ____

List any medication or anesthesia given, and why: _____

Was labor induced? ☐ Yes ☐ No
If yes, why? _____

Was your child born headfirst? ☐ Yes ☐ No ☐ I don't know

Were forceps used? ☐ Yes ☐ No ☐ I don't know
If yes, why? _____

Did you have a cesarean section? ☐ Yes ☐ No
If yes, why? _____

Was this a multiple birth? ☐ Yes ☐ No
If yes, how many? _____

Did your baby have any of the following?

Meconium staining	☐ Yes	☐ No	☐ I don't know
Birthmarks	☐ Yes	☐ No	☐ I don't know
Breathing problems	☐ Yes	☐ No	☐ I don't know
Cord around the neck	☐ Yes	☐ No	☐ I don't know

Did your baby cry quickly? ☐ Yes ☐ No ☐ I don't know

Was your baby's color normal? ☐ Yes ☐ No ☐ I don't know

If your baby's color was yellow (jaundiced), did s/he receive any of the following?

Oxygen ☐ Yes ☐ No

Transfusions ☐ Yes ☐ No

Phototherapy ☐ Yes ☐ No

Were there any other complications before you took your baby home? _____

EARLY HISTORY

GENERAL

Did your baby have feeding problems? ☐ Yes ☐ No

If yes, describe: _____

Was your baby colicky? ☐ Yes ☐ No If yes, how long? ___

Did your baby require formula changes? ☐ Yes ☐ No

If yes, describe: _____

Did your baby have difficulty with any of the following?

☐ Sucking ☐ Chewing ☐ Drooling past 2 ½ months

Was your baby?

☐ Active ☐ Limp ☐ Stiff ☐ Trembling

As an infant or toddler, did your child have poor muscle control in any of the following?

☐ Neck ☐ Trunk ☐ Legs

☐ Chest ☐ Arms ☐ Fingers

Did your baby fail to grow normally? ☐ Yes ☐ No

Did your baby fail to gain weight? ☐ Yes ☐ No

Was this baby different in any way from his/her siblings? ☐ Yes ☐ No

If yes, describe: _____

_____

TOILETING

Toilet trained: ☐ Early ☐ Average (13-36 months) ☐ Late

Did your child have enuresis (bedwetting)? ☐ Yes ☐ No

If so, age began: _____ Age controlled: _____

Did your child have urine accidents during the day? ☐ Yes ☐ No

Did your child have soiling accidents? ☐ Yes ☐ No

MOTOR MILESTONES

At what age did your child:

Sit alone _____ Pedal tricycle _____ Dress self ____ Swim ____
Tie shoes ____ Ride bicycle _____ Feed Self ____

Crawled: ☐ Early ☐ Average (6-9 months) ☐ Late

Walked 2-3 steps alone: ☐ Early ☐ Average (9-18 months) ☐ Late

Which hand does your child prefer: ☐ Left ☐ Right

Does your child switch hands? ☐ Yes ☐ No

SPEECH/LANGUAGE MILESTONES

At what age did your child:

Speak first words _____ Sentence structure _____ put 2-3 words together ____

Speech/Articulation Problems (e.g. stuttering, hard to understand, etc.) ☐ Yes ☐ No
If yes, describe: _____

Followed simple commands: ☐ Early ☐ Average (12-18 months) ☐ Late

Use single words/sentences: ☐ Early ☐ Average (12-24 months) ☐ Late

SENSORY SENSITIVITIES & AVERSIONS

Does your child have a history of any of the following sensory sensitivities or aversions?

☐ Hypersensitivity to sound ☐ Hypersensitivity to light ☐ Hypersensitivity to touch
If yes, describe: _____

Does your child engage in any of the following behaviors?

☐ Hand flapping ☐ Echolalia (parroting others) ☐ Spinning objects
☐ Rocking ☐ Repeating words or phrases ☐ Lining up objects
☐ Pacing ☐ Making loud noises ☐ Difficulty with transitions
☐ Head banging ☐ Repetitive movements ☐ Self-injurious behavior

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MEDICAL HISTORY

Current height: ____ft. ____in. Current weight: ____lbs.

Has your child ever experienced:

☐ High or prolonged fevers ☐ Frequent ear infections ☐ Broken bones
☐ Visual defects ☐ Hearing Defects

Does your child frequently complain of any of the following:

☐ Headaches ☐ Stomachaches ☐ Nausea
☐ Dizziness ☐ Chronic constipation ☐ Trouble hearing
☐ Weakness ☐ Chronic diarrhea ☐ Vision issues

Has your child ever been hospitalized? ☐ Yes ☐ No
If yes, at what age and for what? _____

Has your child ever had any surgeries? ☐ Yes ☐ No
If yes, at what age and what operation? _____

Has your child ever swallowed any paint, poison, drug or non-food object? ☐ Yes ☐ No
If yes, at what age, and what substance? _____

Has your child ever had a seizure due to a fever or unknown causes? ☐ Yes ☐ No
If yes, describe: _____

Has your child ever been "dazed" ("bell rung") or knocked unconscious? ☐ Yes ☐ No
If yes, describe: _____

Has your child ever suffered a brain injury in an accident or assault? ☐ Yes ☐ No
If yes, describe: _____

CONDITIONS

Please check the following diseases or conditions your child has had:

☐ Anemia	☐ Diabetes	☐ Leukemia	☐ Rheumatic Fever
☐ Asthma	☐ Eating disorder	☐ Lung Disorder	☐ Tuberculosis
☐ Bleeding disorder	☐ Encephalitis	☐ Measles	☐ Whooping Cough
☐ Brain stroke	☐ Enzyme deficiency	☐ Meningitis	☐ Trouble Hearing
☐ Broken bones	☐ Facial or other tics	☐ Metabolic disorder	☐ Chicken pox
☐ Cancer	☐ Genetic disorder	☐ Mumps	☐ Colds (excessive)
☐ Heart disorder	☐ Kidney disorder	☐ Pneumonia	☐ Oxygen deprivation

SLEEP

What time does your child typically go to bed? _____ Arise? _____

Does your child have any of the following?

- ☐ Trouble falling asleep
- ☐ Trouble staying asleep
- ☐ Sleepwalking
- ☐ Excessive movement
- ☐ Nightmares
- ☐ Snoring

INTERVENTION HISTORY

List any medication your child is currently taking:

Name(s)	*Dosage*	*Reason*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any medications your child has taken in the past for more than a month:

Name(s)	*Dosage*	*Reason*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever had a bad reaction to any medication? ☐ Yes ☐ No

If yes, describe: _____

Has your child ever received any psychological or psychiatric treatment? ☐ Yes ☐ No

If yes, when and by whom? _____

Please list all of the doctors, therapists, and other providers currently treating your child:

Name(s)	*Specialty*
_____	_____
_____	_____
_____	_____
_____	_____

Which therapies have been provided to your child?

- ☐ Biofeedback
- ☐ Chiropractic treatment
- ☐ Cognitive rehabilitation
- ☐ Homeopathic treatment
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Psychotherapy
- ☐ Speech therapy
- ☐ Vision therapy

FAMILY HISTORY OF BEHAVIORAL HEALTH CONCERNS

Did anyone in your immediate family have (or experience) any of the following?

Problems similar to your child	☐ Yes	☐ No	_____
Neurological disease	☐ Yes	☐ No	_____
Seizures	☐ Yes	☐ No	_____
Anxiety	☐ Yes	☐ No	_____
Depression	☐ Yes	☐ No	_____
Bipolar Disorder	☐ Yes	☐ No	_____
Schizophrenia	☐ Yes	☐ No	_____
Obsessive-Compulsive Disorder	☐ Yes	☐ No	_____
Autism/Asperger's	☐ Yes	☐ No	_____
Suicide	☐ Yes	☐ No	_____
Alcoholism	☐ Yes	☐ No	_____
Drug abuse	☐ Yes	☐ No	_____
Attention problems	☐ Yes	☐ No	_____
Hyperactivity	☐ Yes	☐ No	_____
Learning problems	☐ Yes	☐ No	_____
Reading or spelling difficulties	☐ Yes	☐ No	_____
Speech or language problems	☐ Yes	☐ No	_____

SCHOOL HISTORY

Does your child like school? ☐ Yes ☐ No

Did your child attend nursery school or a preschool program? ☐ Yes ☐ No
Age started: _____
Were there any problems? _____

Did your child have problems with learning any of the following in preschool?
☐ Colors ☐ Shapes ☐ Numbers ☐ Letters

Did your child attend kindergarten? ☐ Yes ☐ No
Age started: _____
Were there any problems? _____

Did your child attend 1st grade? ☐ Yes ☐ No
Age started: _____
Were there any problems? _____

Has the school currently reported problems with any of the following?
☐ Reading ☐ Arithmetic ☐ Following directions
☐ Spelling ☐ Attention span ☐ Social adjustment
☐ Writing ☐ Behavior

Has any psychological testing been done at school? ☐ Yes ☐ No
If yes, where, when and by whom? _____
What recommendations were made? _____

Has your child ever been held back or repeated a grade?
If yes, for which grade(s)? _____
If yes, for what reason(s)? _____

Does your child receive any special services in school? ☐ Yes ☐ No
If yes, what services and for how long? _____

If not now, has your child ever been placed in a special class or provided services under an individualized education plan (IEP) or 504 plan? ☐ Yes ☐ No
If yes, describe: _____

Have you ever privately obtained academic help for your child? ☐ Yes ☐ No
If yes, describe what type, by whom and how often: _____

What grades has your child typically received in the past year?

- ☐ A's & B's
- ☐ B's & C's
- ☐ C's & D's
- ☐ D's & F's

- ☐ Outstanding
- ☐ Good
- ☐ Satisfactory
- ☐ Improvement needed
- ☐ Unsatisfactory

*Are these grades consistent with previous years? ☐ Yes ☐ No

In what subject does your child do best? _____ Have most difficulty? _____

In the past year, has your child been absent?

☐ Less than 2 weeks ☐ 2 – 4 weeks ☐ 5 – 8 weeks ☐ More than 8 weeks

Briefly describe the reasons for absences: _____

_____

BEHAVIOR & SOCIAL HISTORY

Does your child…

Have difficulty getting along with other children his/her own age?	☐ Yes ☐ No
Have difficulty getting along with adults?	☐ Yes ☐ No
Have problems making friends in school?	☐ Yes ☐ No
Have problems getting along with teachers?	☐ Yes ☐ No
Get sick in the morning before school?	☐ Yes ☐ No
Get disciplined frequently at school?	☐ Yes ☐ No
Have emotional, adjustment, or behavioral problems?	☐ Yes ☐ No
Understand others' feelings?	☐ Yes ☐ No
Get along with siblings?	☐ Yes ☐ No
Have a sense of humor?	☐ Yes ☐ No
Understand social cues?	☐ Yes ☐ No
Have empathy for others?	☐ Yes ☐ No

How does your child occupy his/her time? _____

_____

Has your child ever participated in team sports or other competitive sports?

If yes, which ones: _____

How does your child perform athletically? _____

Additional Comments:

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