Pediatric History Form

Please fill out this form to the best of your knowledge. If some questions are not applicable to you or your child, mark N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

Child's Name: ____________________________ Date form completed: __________________
Child's DOB: ____________________________ Child's Age: __________________
Form Completed by: ____________________ Relationship to Child: __________________

Referral Information

Who referred you to Access Point's Pediatric Neurobehavioral Diagnostics Division?

____

*If you do not want a copy of our report sent to the referral source, please check the box. ☐ Do not send

Current Concerns

What is the main reason(s) for seeking a Neuropsychological Examination?

____
____
____

How long has your child experienced or demonstrated these problems?

____
____
____

Family History

Is the child adopted? ☐ Yes ☐ No If "yes", please complete the foster/adoption history at the end of this form.

In foster care? ☐ Yes ☐ No If "yes", please complete the foster/adoption history at the end of this form.

Are the parents: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If separated, date of separation? ____
Who has physical custody of the child? ____
Who has legal custody of the child? ____

How often does other parent see the child? ____

List all people with whom the child currently lives with:

Name of Person in House	Age	Gender	Relationship to Child

If any brothers or sisters are living outside the home, list their names, ages, where they are living, and why they are no longer in your home:

Name	Age	Currently Living In	Reason No Longer in the Home

Have there been any major changes within the family life or the child's living situation that have affected your child's development (e.g., deaths, moves, divorces, loss of job, etc.)? ☐ Yes ☐ No
* If "Yes", describe below

Event	Date	Child's Age at Time

Prenatal Period

Did mother receive prenatal care during the pregnancy? ☐ Yes ☐ No

Did mother have any of the following during or immediately before/after the pregnancy (check all that apply):

☐ Emotional stress
☐ Toxemia
☐ Preeclampsia
☐ Serious illness
☐ Vaginal bleeding
☐ Excessive swelling
☐ Rh incompatibility

☐ Infections (cold, flu)
☐ Anemia
☐ Measles/German measles
☐ High blood pressure
☐ Strep throat
☐ Epilepsy/seizure
☐ Diabetes

☐ Preterm labor
☐ Excessive weight gain
☐ Kidney disease
☐ Maternal injury
☐ Threatened miscarriage
☐ High fever
☐ Excessive Nausea OR ☐ vomiting

☐ Operation or hospitalization during pregnancy: (specify): ______________________________

Were any of the following used during pregnancy? (check all that apply)

☐ Prescribed medications ☐ Marijuana ☐ Methamphetamines
☐ Tobacco ☐ Heroin ☐ Methadone
☐ Amphetamines ☐ Alcohol ☐ Other (specify):________

If yes to any of the above, please specify amount and occasions: ________________________
____

Birth & Developmental History

Was infant born full term? ☐ Yes ☐ No Number of weeks gestation: _____________
Birth Weight? _____ lbs. _____ oz.

Type of Labor Onset? ☐ Induced ☐ Spontaneous

Type of Birth? ☐ Vaginal ☐ C/Section
If C/Section is checked, was it:
Planned ☐ Yes ☐ No
Emergency ☐ Yes ☐ No

Type of Anesthesia: ☐ Gas ☐ Spinal ☐ Local ☐ None

Baby's Presentation: ☐ Breech ☐ Head ☐ Transverse (sideways)

Please check the following problems that may have occurred during labor (check all that apply)

☐ Toxemia ☐ Fetal Distress
☐ Eclampsia ☐ Maternal medications used (please specify): _____________________
☐ Maternal Fever ☐ Use of forceps
☐ Other complications (specify): ____

Length of Active Labor: _________ Hours

Describe any complications during delivery: ____
____

Check if any of the following problems may have occurred within the first few days after the child's birth:

☐ Trouble Breathing
☐ Cord around the neck (# of times ___)
☐ Cardiopulmonary distress
☐ Knot in cord
☐ Seizures
☐ Hemorrhage (bleeding) in head
☐ Hydrocephalus (water on the brain)
☐ Cyanosis (turned blue)
☐ Need for ventilation
☐ Required Oxygen
☐ Required NICU (how long? _________)
☐ Jaundice
☐ Poor Feeding
☐ Required medication
☐ Required a blood transfusion
☐ Vomiting OR ☐ reflux
☐ Floppy muscle tone
☐ Incubator care
☐ Infection
☐ Fever
☐ Injury during delivery: _____________________)
☐ Born with congenital defect: ________________)

Length of stay in hospital: Mother: _______ days Infant: _______ days.

Was any of the following present in your baby during the first 1-2 years of life?

- ☐ Did not enjoy cuddling
- ☐ Difficult to comfort
- ☐ Excessive irritability
- ☐ Unable to separate from parent
- ☐ Extremely passive
- ☐ Temper tantrums
- ☐ Convulsions
- ☐ Colic
- ☐ Destructive Behavior
- ☐ Breathing problems
- ☐ Overactive
- ☐ Difficulty adjusting to schedules
- ☐ Not calmed when held or stroked
- ☐ Excessive restlessness
- ☐ Frequent head banging
- ☐ Sleeping difficulties
- ☐ Early learning problems
- ☐ Withdrawn behavior
- ☐ Repetitive behavior
- ☐ Poor eye contact
- ☐ Difficulty feeding
- ☐ Failure to thrive/poor weight gain
- ☐ Very stubborn
- ☐ Other: specify: ________________________________

Was your child adaptable, easily pleased, easily disciplined as an infant and toddler? ☐ Yes ☐ No
If "No" please describe:

____

____

As an infant and toddler, was your child Interested in social contact (eye contact, Social smile, showing things, sharing experiences)? ☐ Yes ☐ No
If "No" please describe

____

Were developmental milestones achieved on time (e.g., speaking and/or walking on time)? ☐ Yes ☐ No

Please list the approximate age at which your child accomplished the following developmental milestones. If you feel the milestone is not currently appropriate for the age of your child, please check "N/A". If unsure, please check DK.

Age	Milestone	N/A	DK
______	Smile in response (social smile)	☐ N/A	☐ DK
______	Sit independently	☐ N/A	☐ DK
______	Crawl independently	☐ N/A	☐ DK
______	Walk independently	☐ N/A	☐ DK
______	Say "mama" or "dada" specifically	☐ N/A	☐ DK
______	Say 1st word other than "mama" or "dada"	☐ N/A	☐ DK
______	Put two words together	☐ N/A	☐ DK
______	Put 4-5 sentences together to relate an experience	☐ N/A	☐ DK
______	You understood 100% of what child said	☐ N/A	☐ DK
______	Knew primary colors	☐ N/A	☐ DK
______	Say the letters of the alphabet	☐ N/A	☐ DK
______	Print first and last name	☐ N/A	☐ DK
______	Tie shoes	☐ N/A	☐ DK
______	Snap, zip, button clothing	☐ N/A	☐ DK
______	Began to read	☐ N/A	☐ DK
______	Toilet trained (urine)	☐ N/A	☐ DK
______	Toilet trained (bowel)	☐ N/A	☐ DK

Has your child ever lost skills that at one time he/she was able to perform? ☐ Yes ☐ No
If "Yes" explain:

____
____
____

Are there any concerns related to toilet training? ☐ Yes ☐ No (If "yes" explain):

____
____
____

Medical/Mental Health History

Is your child under the care of other medical providers or specialists? ☐ Yes ☐ No
If "Yes", for what? ________________ Name of Provider ________________________
________________ ________________________
________________ ________________________
________________ ________________________

Does your child have or have a history of:

Vision Problems ☐ Yes ☐ No Wears Glasses ☐ Yes ☐ No
Hearing Problems ☐ Yes ☐ No Wears Hearing Aid ☐ Yes ☐ No

Appetite concerns? ☐ Normal ☐ Picky ☐ Eats too much ☐ Weight Loss ☐ Weight Gain

Where does your child sleep? ☐ Own Bedroom ☐ Parent(s) Room ☐ Shares Bedroom
Does your child have problems falling asleep? ☐ Yes ☐ No
If "Yes", how long does it take for him/her to fall asleep? ___________ hours.

Does your child wake up in the middle of the night? ☐ Yes ☐ No
If "Yes", typically how many times per night? ___________________________________

How long does it take for him/her to go back to sleep? ___________________________________

How many hours does your child currently sleep at night? _______________________________

Oral Motor Concerns? ☐ None ☐ Difficulty swallowing ☐ Drooling ☐ Gagging

Please indicate if your child has been given any of the following diagnoses:

☐ Epilepsy / Seizure Disorder
☐ Diabetes
☐ Thyroid Disorder
☐ Blood Disorder
☐ Asthma
☐ Allergies, __________________
☐ Tourette's / Tic Disorder
☐ Cancer
☐ Childhood Disease:__________
☐ Other: ____________________

☐ Mental Retardation
☐ Autism/Asperger's/PDD
☐ Fragile X
☐ Developmental Delay
☐ Learning disability
☐ Language Disorder
☐ Traumatic Brain Injury
☐ High Blood Pressure
☐ Genetic Disorder: ______________________________

☐ Anxiety Disorder
☐ Depression
☐ Bipolar Disorder
☐ Schizophrenia
☐ Conduct Disorder
☐ Oppositional Defiant Dis.
☐ Attention Deficit (ADHD)

Please indicate if your child has/had problems with:

- ☐ Chronic earaches/infections
- ☐ Frequent stomach aches
- ☐ High fevers (over 103)
- ☐ Encephalitis
- ☐ Meningitis
- ☐ Poisoning or drug intoxication
- ☐ Frequent and/or severe headaches
- ☐ Crossed eyes
- ☐ Excessive bleeding or bruising
- ☐ Endocrine / Gland Problems
- ☐ Growth problems
- ☐ Immune system disorders
- ☐ Coma
- ☐ Other: ________________________
- ☐ Ear Tubes, if so number of tube placements:___
- ☐ Frequent vomiting
- ☐ Poor eating habits
- ☐ Staring spells
- ☐ Constipation
- ☐ Urine infections
- ☐ Daytime wetting or accidents
- ☐ Soiling accidents
- ☐ Bedwetting
- ☐ Frequent urine or bladder problems/infections
- ☐ Paper and pencil coordination problems
- ☐ Tremors or twitches, specify: ________________
- ☐ Balance or coordination problems, gross motor concerns

Surgeries: Age ___________ Reason: _________________________ Where: ____________
Other details: ____

Hospitalizations: Age ___________ Reason: ______________________Where: ____________
Other details: ____

Major accidents or injuries: Age: _____ Reason: ________________ Where: ____________
Other details: ____

Has your child ever been unconscious? ☐ Yes ☐ No If "Yes", please explain: _________
____
____
____
____

Medications: ☐ Yes ☐ No If "Yes", describe below:

Current Medication(s)	Dosage	Frequency	Start Date	Reason for Taking
Previous Medications	Dosage	Frequency	Start-End Date	Reason for Stopping

Has your child had any of the following tests or evaluations?

- ☐ CT Scan of Head Results: ______________________________
- ☐ MRI Scan of Head Results: ______________________________
- ☐ EEG Results: ______________________________
- ☐ Audiology/Hearing Evals. Results: ______________________________
- ☐ Vision Evaluation Results: ______________________________
- ☐ Genetic Testing Results: ______________________________
- ☐ Other Laboratory Tests Results: ______________________________

Is your child receiving (or has received) any of the following, either privately or through school?

Service/Intervention	Current/Date(s)	Past/Date(s)	Providers Name / Agency
☐ Neurological Exam	________	________	________
☐ Psychiatric Exam	________	________	________
☐ Psychological Evaluation	________	________	________
☐ Psychological Testing	________	________	________
☐ Therapy/Counseling	________	________	________
☐ Social Skills Class	________	________	________
☐ Parenting Class	________	________	________
☐ Residential Treatment	________	________	________
☐ Psychosocial Rehab/PSR	________	________	________
☐ IBI	________	________	________
☐ Developmental Therapy	________	________	________
☐ Speech / Language	________	________	________
☐ Occupational Therapy	________	________	________
☐ Physical Therapy	________	________	________
☐ Other:	________	________	________

Family Medical/Mental Health History

Please indicate if any of the child's family members have/had the following problems/disorders:

- ☐ Birth Defect
- ☐ Genetic Disorder: ______________________
- ☐ Cerebral Palsy
- ☐ Severe Head Injury
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Physical disability: ______________________
- ☐ Tuberous Sclerosis
- ☐ Huntington's chorea
- ☐ Muscular Dystrophy
- ☐ Sickle-cell anemia
- ☐ Seizures or epilepsy
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Alcohol / Drug Abuse
- ☐ Physical / Sexual Abuse
- ☐ Learning Disability: ______________________
- ☐ Speech / Language Delay
- ☐ Developmental Delay
- ☐ Motor Coordination Problems
- ☐ Mental Retardation
- ☐ Autism / Asperger's / PDD
- ☐ Attention Deficit Disorder
- ☐ Oppositional / Defiant Behaviors
- ☐ Antisocial Behavior
- ☐ Aggression
- ☐ Tics / Tourette's Disorder
- ☐ Nervousness / Anxiety
- ☐ Obsessive-Compulsive Disorder
- ☐ Depression
- ☐ Bipolar / Manic Depressive Disorder
- ☐ Schizophrenia
- ☐ Other: ______________________

Educational History

Name of child's current school: ______________________________
Grade (if summertime, please indicate grade entering upcoming school year) ______________

Has your child received Early Childhood Intervention Services? ☐ Yes ☐ No (Dates:________)

Were there any adjustment problems when your child first entered school? ☐ Yes ☐ No

Has your child ever been held back? ☐ Yes ☐ No What Grade? _______ Why?: _______
____

If your child is in school, please comment on the areas below:

Reading	☐ Above Average	☐ Average	☐ Problematic
Writing	☐ Above Average	☐ Average	☐ Problematic
Mathematics	☐ Above Average	☐ Average	☐ Problematic
Interactions with Teachers	☐ Above Average	☐ Average	☐ Problematic
Interactions with Peers	☐ Above Average	☐ Average	☐ Problematic
Participation in Organized	☐ Above Average	☐ Average	☐ Problematic

Has testing been completed by the School? ☐ Yes ☐ No

Present Class Placement:
☐ Regular Education Classroom
☐ Special Education Class
If "checked", please specify: ________________
____
____
____
☐ Bilingual/ESL Services
☐ Gifted and Talented Services

Does the child receive educational services through an IEP or 504 Plan? ☐ Yes ☐ No
If "Yes", for what classification? ________________
____
____
____

Have any of the following instructional modifications been attempted?

- ☐ Oral tests
- ☐ Additional instructions
- ☐ Manipulatives in math
- ☐ Preferential seating
- ☐ Extended time to complete assignments
- ☐ Shortened or modified assignments
- ☐ Study sheets
- ☐ Control of distractions
- ☐ Behavior modification program
- ☐ Peer teaching
- ☐ Reduced paper and pencil work
- ☐ Repeated review
- ☐ Study carrel
- ☐ Outlines
- ☐ Positive reinforcers
- ☐ Behavior check cards / charts
- ☐ Predictable routines and classroom rules
- ☐ Increased positive feedback
- ☐ Technologic assistance (word processor, calculator, communication device, etc.)
- ☐ Other: ______________________________________

Personal / Social Information

What about your child makes you most proud? ______________________________
____

Please describe your child in ONE sentence? ______________________________
____

What are your child's main hobbies and interests? ______________________________
____

What does your child dislike doing most? ______________________________
____

How many **close** friends does your child have? ______________________________

Does your child have a best friend? ☐ Yes ☐ No How is he/she: _____

How easily does your child make friends? ☐ Average ☐ Worse than Average

Does your child have problems keeping friends? ☐ Yes ☐ No

How well does your child get along with friends? ☐ Average ☐ Worse than Average

Does your child get along best with:
☐ Older children ☐ Children same age ☐Younger Children

Behavior and Discipline

Please describe briefly any behavioral problems at school: ______________________________
____

Has your child ever been assigned:
☐ Out of School Suspension: # of Suspensions _____
☐ In School Suspension: # of Suspensions _____
☐ Expulsion # of Expulsions _____

Please describe briefly any behavioral problems at home: ______________________________
____

Types of discipline you use with your child:

☐ Rewards
☐ Time out (isolation)
☐ Ignoring behavior
☐ giving in to child
☐ Verbal reprimands / verbal demands
☐ Removal of privileges
☐ Physical punishment
☐ Other (please specify): ______________________________

Which form(s) of discipline has proven most effective? ______________________________
____

Which form(s) of discipline has proven least effective? ______________________________
____

Please indicate if your child has difficulties with any of the following **ONLY** if these difficulties are **SIGNIFICANT** or **INTERFERE** with your child's daily functioning or they go beyond what would be **NORMALLY** expected for child of his or her age:

- ☐ Social Isolation
- ☐ Timid / Shy
- ☐ Often bullied, threatened, or intimated by others
- ☐ Temper Tantrums
- ☐ Low Frustration Tolerance
- ☐ Attention Seeking Behavior
- ☐ Laziness
- ☐ Does not pay attention to detail or makes careless mistakes
- ☐ Has difficulty keeping attention to what needs to be done
- ☐ Does not seem to listen when spoken to directly
- ☐ Does not follow through when given directions/ fails to finish activities (not due to refusal or failure to understand)
- ☐ Has difficulty organizing tasks and activities
- ☐ Avoids, dislikes, or does not want to start tasks that require ongoing mental effort
- ☐ Loses things necessary for tasks or activities (assignments, pencils, books)
- ☐ Is easily distracted by noises or other stimuli
- ☐ Is forgetful of daily activities
- ☐ Fidgets with hands or feet or squirms in seat
- ☐ Leaves seat when remaining in seat is expected
- ☐ Runs about or climbs too much
- ☐ Has difficulty playing or beginning quiet activities
- ☐ Is "on the go" or acts as if "driven by a motor"
- ☐ Talks too much
- ☐ Blurts out answers before questions have been completed
- ☐ Has difficulty waiting his or her turn
- ☐ Interrupts or intrudes in on others' conversations and/or activities
- ☐ Loses temper
- ☐ Argues with adults/teachers
- ☐ Actively defies or refuses to go along with adults' requests or rules
- ☐ Deliberately annoys people
- ☐ Blames others for his or her mistakes or misbehaviors
- ☐ Is touchy or easily annoyed by others
- ☐ Is angry and resentful
- ☐ Is spiteful and wants to "get even"
- ☐ Bullies, threatens, or intimidates others
- ☐ Starts physical fights
- ☐ Lies to get out of trouble, avoid obligations, or to obtain goods or favors
- ☐ Is truant from school without permission
- ☐ Is physically cruel to people
- ☐ Is physically cruel to animals
- ☐ Has stolen from teachers or classmates
- ☐ Deliberately destroys others' property
- ☐ Has used a weapon that can cause physical harm (bat, knife, brick, gun, etc.)
- ☐ Has deliberately set fires to cause damage
- ☐ Uses profanity
- ☐ Gang Involvement
- ☐ Alcohol / Substance use

- ☐ Cigarette use
- ☐ Depressed mood, unhappiness
- ☐ Decreased interest or pleasure in daily activities
- ☐ Has low energy or fatigue
- ☐ Seems excessively agitated
- ☐ Seems excessively slowed down
- ☐ Excessively crying
- ☐ Has difficulty making decisions
- ☐ Has feelings of hopelessness
- ☐ Lack self-confidence
- ☐ Low self-esteem
- ☐ Fainting, falling down
- ☐ Unusual fears
- ☐ Avoidance
- ☐ Has excessive anxiety or worry
- ☐ Feels that worry is difficult to control
- ☐ Is restless or feels keyed up or "on edge"
- ☐ Is easily fatigued
- ☐ Excessive irritability
- ☐ Has muscle tension
- ☐ Has repetitive behaviors such as hand-washing, lining things up, checking on things before leaving a room, or mental acts such as a need to keep counting things or repeating words over and over.
- ☐ Has thoughts that persist and keep coming back, that cause worry or anxiety

Adoptive / Foster History

(Please complete this section only if the child has ever been adopted or placed in foster care)

What age was the child first placed in foster care? ______________________________

Why was the child placed in foster care? ______________________________

____

Who has legal custody of the child? ______________________________
Name of child's social worker? ______________________________
Social Worker Address: ______________________________
Social Worker's Contact Numbers: Ph: ____________ Fax: ____________

Has the social worker provided consent for this evaluation? ☐ Yes ☐ No
(If "Yes", please attach authorization: If "No", please request authorization from social worker)
Is the child adopted? ☐ Yes ☐ No If "Yes", specify country of origin if international: ________

Age when child was first in home? ____________ Date of Legal Adoption: __________

If the child was adopted, do they know they were adopted? ☐ Yes ☐ No

How many different foster care / adoptive placements has the child experienced? __________

What type of placements has the child experienced?

- ☐ Orphanage
- ☐ Foster Home
- ☐ Group Home
- ☐ Shelter Care
- ☐ Kinship Home
- ☐ Hospitalization

Does the child have any contact with biological parents? ☐ Yes ☐ No

If "Yes", with:

Whom: ______________________________

How Often: ______________________________

Supervised Visits: ______________________________

How does the child respond after the visits: ______________________________

If the child is not yet adopted, is there a plan for this to happen? ☐ Yes ☐ No

If "Yes", what is the time frame? ______________________________

How has the child adjusted to foster care / adoption? ______________________________

____

____

____

____

____

____