PEDIATRIC NEURODEVELOPMENTAL HISTORY FORM

______________________________
Child’s Name

_______________________________
Date Completed

______________________________
Person Completing Form
Child’s Full Legal Name __________________________________________________________

Gender _____ Birth Date ________ Current Age ________ Current Grade ________

School __________________________ District __________________________

Child presently lives with:

_____ Biological Parents     _____ Mother      _____ Father/Step Mother     _____ Other

_____ Adoptive Parents     _____ Father      _____ Mother/Step Father

Referred by _________________________________________________________

Reason for referral: ________________________________________________

What most concerns you about your child? _______________________________

What are you hoping to learn and understand about your child by having an evaluation completed?
____________________________________________________________________
____________________________________________________________________

What changes are you hoping to make (or what development are you hoping to encourage) in your child by having this evaluation? ________________________________
____________________________________________________________________
____________________________________________________________________

List any professionals to whom you would like the final report sent:
(If you do not provide address information, the report will not be sent)

Name        Address        Phone/Fax
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Please note that you will still need to sign a release of information in office for each party listed above to whom you want information released.
**SECTION I. FAMILY AND SOCIAL HISTORY**

Marital status of primary caregiver(s):

- [ ] Single
- [ ] Separated
- How long? ______________
- [ ] Married
- [ ] Divorced
- Date of divorce ____________
- [ ] Cohabiting

Biological/Adoptive/Step/Foster Mother: ___________________________ Age: ______

Education:
- Highest grade completed ____________ (1-12) High school graduate/GED (circle one)
- Number of college credit hours completed ____________________________
- Highest degree awarded ____________________________________________
- Vocational Training _____________________________ Years _____________
- Current employment ____________________________________________ Hours/wk ______

Biological/Adoptive/Step/Foster Father: ___________________________ Age: ______

Education:
- Highest grade completed ____________ (1-12) High school graduate/GED (circle one)
- Number of college credit hours completed ____________________________
- Highest degree awarded ____________________________________________
- Vocational Training _____________________________ Years _____________
- Current employment ____________________________________________ Hours/wk ______

Adoptive/Step/Foster Parent: ___________________________ Age: ______

Education:
- Highest grade completed ____________ (1-12) High school graduate/GED (circle one)
- Number of college credit hours completed ____________________________
- Highest degree awarded ____________________________________________
- Vocational Training _____________________________ Years _____________
- Current employment ____________________________________________ Hours/wk ______

Adoptive/Step/Foster Parent: ___________________________ Age: ______

Education:
- Highest grade completed ____________ (1-12) High school graduate/GED (circle one)
- Number of college credit hours completed ____________________________
- Highest degree awarded ____________________________________________
- Vocational Training _____________________________ Years _____________
- Current employment ____________________________________________ Hours/wk ______

Additional children in the family:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Medical, social or school problems?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Only if your child was adopted, please complete Section II.*
For the child’s biological relatives, is there any history of the following? (please complete from child’s relationship: M = Mother, F = Father, S = Sister, B = Brother, GM = Grandmother, GF = Grandfather, U = Uncle, A = Aunt, C = Cousin, etc.)

<table>
<thead>
<tr>
<th>Mother’s side of family</th>
<th>Father’s side of family</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ Learning problems</td>
<td>_____ Learning problems</td>
</tr>
<tr>
<td>_____ School problems</td>
<td>_____ School problems</td>
</tr>
<tr>
<td>_____ Attention/concentration problems</td>
<td>_____ Attention/concentration problems</td>
</tr>
<tr>
<td>_____ Hyperactivity</td>
<td>_____ Hyperactivity</td>
</tr>
<tr>
<td>_____ Anxiety</td>
<td>_____ Anxiety</td>
</tr>
<tr>
<td>_____ Obsessive-Compulsive Disorder</td>
<td>_____ Obsessive-Compulsive Disorder</td>
</tr>
<tr>
<td>_____ Depression</td>
<td>_____ Depression</td>
</tr>
<tr>
<td>_____ Alcoholism/Drug Abuse</td>
<td>_____ Alcoholism/Drug Abuse</td>
</tr>
<tr>
<td>_____ Developmental Disability</td>
<td>_____ Developmental Disability</td>
</tr>
<tr>
<td>_____ Intellectual Disability</td>
<td>_____ Intellectual Disability</td>
</tr>
<tr>
<td>_____ Autism/Pervasive Developmental Disorder</td>
<td>_____ Autism/Pervasive Developmental Disorder</td>
</tr>
<tr>
<td>_____ Bipolar Disorder</td>
<td>_____ Bipolar Disorder</td>
</tr>
<tr>
<td>_____ Seizure Disorder</td>
<td>_____ Seizure Disorder</td>
</tr>
<tr>
<td>_____ Genetic Disorder</td>
<td>_____ Genetic Disorder</td>
</tr>
<tr>
<td>_____ Head Injury</td>
<td>_____ Head Injury</td>
</tr>
<tr>
<td>_____ Metabolic Disease</td>
<td>_____ Metabolic Disease</td>
</tr>
<tr>
<td>_____ Other neurologic condition</td>
<td>_____ Other neurologic condition</td>
</tr>
</tbody>
</table>

Have any of your child’s biological relatives experienced problems similar to those your child is currently experiencing? If so, please describe ____________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

SECTION II: ADOPTION ADDENDUM

Age at adoption: __________________________ Country/state of birth: __________________
Is this an open adoption? Yes No If yes, briefly explain: _________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Any failed adoptions? Yes No If yes, list reason _________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Foster placements? Yes No Number of placements __________________________
Approximate length of each placement ____________________________________________
__________________________________________________________________________________________

Please describe any concerns related to your child’s adjustment to his/her adoption: __________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Please check all that apply to your adopted child:

_____ Difficulty with bonding
_____ Difficulty with eye contact
_____ Social Withdrawal
_____ Over-friendly with strangers

Better behaved outside the home
_____ Excessive reaction to minor events
_____ Indifferent to family members
SECTION III: PSYCHOSOCIAL HISTORY

Describe father’s and/or step/foster father’s personality:

Describe father’s and/or step/foster father’s relationship with patient:

Describe mother’s and/or step/foster mother’s personality:

Describe mother’s and/or step/foster mother’s relationship with patient:

Do you and your partner/other caregiver agree on the parenting style for this child?  Yes  No
Please explain briefly:

Describe any problems between patient and siblings:

Describe overall, general family relationships:

Have there been any abuse issues in the family? (neglect, emotional, physical, sexual)  Yes  No
Please explain briefly:
SECTION IV: PREGNANCY AND BIRTH HISTORY

1. How many weeks did pregnancy last (normal 38-42 weeks): ____________________
   (If the child was premature, please complete Section XIV: Prematurity and Newborn Intensive Care Addendum)

2. Please list any medications taken during pregnancy (include vitamins, all prescription drugs and over-the-counter drugs)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Months Take (of 9)</th>
<th>Dose</th>
<th>Reasons for taking Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Was alcohol consumed during pregnancy?  Yes   No

4. Was there smoking or tobacco used during pregnancy  Yes   No

5. Were any other drugs (not prescribed) used during pregnancy?  Yes   No
   If yes, please describe the drug(s) and how often:

6. Were there any illnesses during pregnancy?  Yes   No

7. Were there any traumas during pregnancy?  Yes   No
   If yes, please describe:

8. Was an amniocentesis done during pregnancy?  Yes   No
   If yes, please describe results:

9. Was there any exposure to chemical, toxic substances, or people with infections during the pregnancy?  Yes   No
   If yes, describe:

10. Were there any difficulties in the child during or immediately after birth?  Yes   No
    If yes, please complete Section XV: Prematurity and Newborn Intensive Care Addendum

11. Did your child nurse?  Yes   No
    If yes, were there any difficulties with:  latching on, coordinating suck/breathe/swallow

Child’s birth weight ___________ pounds ________________ ounces
Child’s birth length _______________ inches

APGAR scores at 1 minute ________________ 5 minutes ________________
SECTION V: DEVELOPMENTAL PROGRESSION

At what point did you become concerned about your child’s development and/or behavior, and why?

__________________________________________________________________________________________________________________________________________________________________________________________________________

Developmental Milestones: (List age and months for each milestone achieved. Approximate if unsure).

__ Rolled over  __ Babbled  __ Ability to hold crayon to color
__ Sat Alone  __ First words (speech or sign)  __ Ability to draw simple figures
__ Crawled  __ 2-3 word sentences  __ Bladder trained (night)
__ Walked  __ Understood “no”  __ Bladder trained (day)
__ Pedaled a tricycle  __ Rode bike without training wheels  __ Bowel trained

Please describe any difficulties with any of the above milestones:

___________________________________________________________________________________________________________________________________________________________________________________________________________

Were any of the following present to an unusual degree during:
I = Infancy (0-18 months);  T = Toddler (18 months-3 years);  or P = Preschool (3-5 years)

__ High fevers  Explanations:
__ Excessive pain/ discomfort
__ Re-occurring ear infections/tubes placed
__ Poisonings/toxic exposure
__ Colic/reflux
__ Poor weight gain
__ Difficulty sucking/chewing/swallowing
__ Difficult to wean/self-weaned early
__ Lethargy
__ Restless
__ Disrupted sleep
__ Difficult to calm/pacify
__ Irritability/easily agitated
__ Did not like to be held
__ Aggression
__ Thumb sucking
__ Nightmares
__ Clumsy/uncoordinated
__ Accident prone
__ Masturbation
__ Highly active
__ Difficulty making eye contact
__ Staring or avoiding looking at things
__ Rocking, spinning, or head banging
__ Walking on tiptoes, or flapping hands
__ Unusual play behaviors
__ Difficulty interacting/playing with others
__ Slow to roll, crawl or walk
____ Slow to use words or sentences
____ Loss of abilities/regression
____ Other _______________________

Is your child: ________ Right-handed ________ Left-handed _________ Ambidextrous

Age handedness became obvious? __________________________

Family history of left handedness? Yes No

Has your child ever changed handedness Yes No

Physical developmental progressing without complications? Yes No

Age at first pubertal development _______________________

Sex education provided at home, school, church? Yes No

Is your child dating? Yes No

Is or has your child been sexually active? Yes No

Taking or using birth control? Yes No

Is or has your child been employed or had small jobs? Yes No

Please explain __________________________________________________________

__________________________________________________________

Check the behaviors that you believe your child currently exhibits to an exaggerated degree compared to siblings of other children of the same age:

___ High activity
___ Impulsivity (poor self-control)
___ Interrupts frequently
___ Poor attention span
___ Acts as if is “driven by a motor
___ Heedless to danger
___ Difficulty finishing tasks
___ Disorganized
___ Accident prone
___ Low frustration tolerance
___ Excessive swearing
___ Unusually aggressive
___ Temer outbursts
___ Clumsy/sloppy
___ Does not listen
___ Does not respond to discipline
___ Socially awkward/odd
___ A “different” child
___ Tics/twitching
___ Binging/Purging
___ Does not understand or learn from consequence or experience
___ Other concerning behavior

__________________________________________________________

Is your child experiencing any of the following problems?

___ Drugs/substance abuse
___ Alcohol
___ Cruelty to animals
___ Actively rebelling
___ Vandalism/stealing
___ Violent behavior
___ Lying/cheating
___ Suicidal threats/gestures
___ Inappropriate sexual behavior
___ History of sexual abuse (victim)
___ History of sexual abuse (perpetrator)
Which specific behaviors interfere with development or family functioning?
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Types of discipline you use or have used with your child: _______________________________ ______________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Is discipline effective?  
Yes  No
Explain: ________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Have you taken any classes on parenting skills?  Yes  No
Check the courses taken/books read:
___ Parenting with Love and Logic  ___ Parent Effectiveness Training  
___ 1-2-3 Magic  ___ Other __________________
___ SOS Help for Parents

SECTION VII: SOCIAL HISTORY

Does your child seek out friends?  Always 1 2 3 4 5  Never
Do other children seek out your child to socialize?  Always 1 2 3 4 5  Never
Does your child relate well to other children?  Always 1 2 3 4 5  Never
Does your child understand the rules of social interaction?  Always 1 2 3 4 5  Never

Are your child’s friends:  older _____  younger _____  same age _____
Please explain problems with friendships: ______________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Who is child’s best friend? ________________________________________________________

Is your child different than his/her peers?  Yes  No
Please explain: ________________________________ ______________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Any difficulties with:
___ Bossy  ___ Initiating play  ___ Compromising
___ Withdrawn  ___ Making new friends  ___ Sharing
___ Disinterested  ___ Keeping old friends  ___ Being accepted
in others  ___ Group play  ___ Individual play

What are the best things about your child? __________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

What are your child’s areas of great accomplishment? _________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
What does your child enjoy doing most? _____________________________________________
______________________________________________________________________________
______________________________________________________________________________
What does your child dislike doing? _________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Does your child participate in sport activities? Yes No
Describe ________________________________________________________________
______________________________________________________________________________
Does your child participate in music or art activities/lessons? Yes No
Describe _____________________________________________________________
______________________________________________________________________________

SECTION VII: SCHOOL EXPERIENCE / LEARNING PROBLEMS

Did/does your child receive Early Intervention? Yes (If so, please bring copy of IFSP) No

<table>
<thead>
<tr>
<th>Schools Attended</th>
<th>Grades</th>
<th>Academic concerns</th>
<th>Behavioral concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschool</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kindergarten</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle/Junior High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High School</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post High School</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To the best of your knowledge, at what grade level is your child currently performing?
Reading ______ Spelling ______ Arithmetic ______ Writing ______

Has your child ever been held back or has retention ever been suggested? Yes No
If yes, please explain: __________________________________________________________
______________________________________________________________________________

Has your child ever been in Title One Resource or Special Education placement? Yes No
If yes, when and for what services? ____________________________________________
______________________________________________________________________________
If applicable, please circle your child’s classification(s) through Special Education:

Autistic Disorder  Emotional/Behavioral Disorder  Communication Disorder
Developmental Delay  Hearing Impaired  Intellectual Disorder
Learning Disabled  Multiply Handicapped  Other Health Impaired
Traumatic Brain Injury  Visually Handicapped

When was the last IEP or 504 Plan, and what were the goals? (Attach if possible) __________________________
________________________________________________________________________
________________________________________________________________________

Does your child receive any of the following in school: (please circle)

- Adapted physical education
- Physical therapy
- Occupational therapy
- Speech therapy
- Counseling
- Tutoring

Does (or has) your child received private tutoring? [ ] Yes  [ ] No
Explain: ______________________________________________________________________
________________________________________________________________________

Has your child received psychological or educational testing by the school? [ ] Yes  [ ] No
*Please provide copies of all previous test results/reports.

Describe the process of doing homework each night with your child: __________________________
________________________________________________________________________
________________________________________________________________________

Has/Have your child’s classroom teacher(s) reported any of the problems below?

- Attention/concentration
- Poor memory
- Anxious or sad
- Distractibility
- Following directions
- Math problems
- Hyperactivity
- Not turning in assignments
- Handwriting
- Behavior problems
- Doesn’t get along well
- Reading/spelling problems
- Aggression
- Withdrawal
- Other __________________________
- Oppositional
- Few friends

Does your child participate in extra-curricular activities at school (e.g. sports, clubs)? If so, what are they?
________________________________________________________________________

SECTION VIII: PRESENT MEDICAL STATUS

Height __________________________  Weight __________________________

Current medical problems for which your child is being treated: __________________________
________________________________________________________________________
________________________________________________________________________

Surgeries: __________________________
Has/Did your child had/have frequent ear infections [ ] Yes  [ ] No

Did he/she have pressure equalization tubes placed? [ ] Yes  [ ] No

Age at time of surgery __________________________
Does your child have any hearing problems?  Yes No
Explain ____________________________________________

Has your child received an audiological evaluation?  Yes No
Date ____________ Results ______________

Has your child received an ophthalmologic evaluation or vision screening?  Yes No
When was your last ophthalmologic evaluation? ______________
With? ______________________________________________________

Does your child have any difficulties with sleep?  Yes No
If so does he/she:
- Struggle to initiate sleep
- Struggle to stay asleep
- Awaken early
- Move excessively in sleep
- Snore
- Talk in sleep
- Night Terrors (how often?)
- Nightmares (how often?)
Explain ________________________________________________________________________________________________
___________________________________________________________________________________________

Is there a family history of sleep disorders?  Yes No

Does your child use or require any special equipment?  Yes No
(Please be sure to bring necessary equipment to evaluation)
- _ crutches
- _ wheelchair
- _ walker
- _ arm/hand splints
- _ leg braces
- _ hearing aid/cochlear implant
- _ glasses
- _ transmitter
- _ cane
- _ other ___________________

SECTION IX: MENTAL HEALTH HISTORY

Has your child received outpatient psychotherapy/counseling?  Yes No
Therapist(s): ____________________________________________

Diagnosis: ________________________________________________

Duration of treatment: ___________________________________

Response to treatment/outcome: ________________________________

Private psychological or developmental testing completed? When and by whom? ________________________________

*Please attach any test results available.
Has your child ever received acute psychiatric care?  

Yes  
No

Has your child ever attended Residential or Day Treatment Programs?  

Yes  
No

Has your child ever attended Residential or Day Treatment Programs?  

Program __________________________  Dates of attendance: ___________________

Program __________________________  Dates of attendance: ___________________

Program __________________________  Dates of attendance: ___________________

Have you used in-home services?  

Yes  
No

Early Intervention  
Family Preservation  
Respite  
In-home Mental Health

List any other agencies/individual providing regular services not mentioned elsewhere:

Name: _______________________________________________________________________

Address: _____________________________________________________________________

Phone: _______________________________________________________________________

Service: _____________________________________________________________________

Name: _______________________________________________________________________

Address: _____________________________________________________________________

Phone: _______________________________________________________________________

Service: _____________________________________________________________________

SECTION X: MEDICATION HISTORY

On the average, how often does your child receive his/her medication in the correct dosage?

a.  < 50% of the time  
b.  50-80% of the time  
c.  81-100% of the time

Is the child responsible for taking any doses of medication?  

Yes  
No

Are medications supervised?  

Yes  
No

Is the school responsible for giving any doses of medication?  

Yes  
No
Please list all past and present medications prescribed and the dosages or attach a list. Typically the child should be administered all regularly prescribed medications for testing. Please discuss with examiner if you have concerns or questions:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Prescribed by</th>
<th>Dosage</th>
<th>Date Started/Ended</th>
<th>Response/Side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SECTION XI: NEUROLOGICAL HISTORY

Please check all that apply to your child:

- Birth Injury
- Developmental disorder
- Seizures
- Meningitis
- Encephalitis
- Traumatic brain injury
- Genetic disorder
- Metabolic disorder
- Endocrine problems
- Spinal cord injury
- Brain tumor
- Tuberous Sclerosis
- Cerebral palsy
- Skull fracture/concussion
- Seizures
- Tuberous Sclerosis
- Genetic disorder
- Metabolic disorder
- Encephalopathy
- Other ____________________________

Age at initial diagnosis

Initial complaints or symptoms:

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Has your child ever had a seizure(s)?

Yes
No

If yes, please complete seizure addendum, section XIV

Has your child experienced any head injury or concussion?

Yes
No

If yes, please complete Accident/Injury Addendum, section XV

Did your child have neurologic problems surrounding birth?

Yes
No

If yes, please complete Prematurity/Neonatal Intensive Care, section XV

History of neurosurgery?

Yes
No

Condition/event

Dates of surgeries

-----------------------------------------------------------------------------------------------------------------------------
-----------------------------------------------------------------------------------------------------------------------------
-----------------------------------------------------------------------------------------------------------------------------

Does your child experience headaches?

Yes
No

Frequency?  ____ times per (please circle)  day  week  month  year

Severity:  mild  1 2 3 4 5 6 7 8 9 10  severe

Does your child have a warning if headaches are about to happen?

Yes
No

What interventions have been or are used for headaches? Please circle those used and underline those that are effective.

Medications  Craniosacral therapy  Hypnosis  None
Massage  Relaxation  Chiropractor
Distraction  Physical therapy  Biofeedback
**SECTION XII: OTHER PROFESSIONALS CONSULTED**

List names and specialties of other professionals previously consulted:

<table>
<thead>
<tr>
<th>Name</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>____________________________</td>
</tr>
<tr>
<td>2.</td>
<td>____________________________________________________________________</td>
</tr>
<tr>
<td>3.</td>
<td>____________________________________________________________________</td>
</tr>
<tr>
<td>4.</td>
<td>____________________________________________________________________</td>
</tr>
</tbody>
</table>

Pediatrician/family physician: ____________________________________________
Address/phone number: ____________________________________________

**SECTION XIII: OTHER RESOURCES**

DSPD Services? Yes No
<table>
<thead>
<tr>
<th>Caseworker</th>
<th>Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has your child ever received physical therapy? Yes No
With whom: ____________________________________________
Date: ____________________________________________
Location: ____________________________________________
Reason for evaluation: ________________________________

Has your child ever received occupational therapy? Yes No
With whom: ____________________________________________
Date: ____________________________________________
Location: ____________________________________________
Reason for evaluation: ________________________________

Has your child ever received speech therapy? Yes No
With whom: ____________________________________________
Date: ____________________________________________
Location: ____________________________________________
Reason for evaluation: ________________________________

Has your child ever been tested by an audiologist? Yes No
With whom: ____________________________________________
Date: ____________________________________________
Location: ____________________________________________
Reason for evaluation: ________________________________
Results: ____________________________________________
SECTION XIV: NEUROLOGICAL HISTORY: SEIZURE ADDENDUM
Complete this section only if your child has a history of seizure activity

Describe the seizures/spells your child had or is currently having.

A. Type
   ____ convulsive generalized
   ____ non-convulsive generalized
   ____ unclassified
   ____ status epilepticus
   ____ partial *(if type is “partial” then complete C and D. If not, continue on the next section)*
   ____ complex
   ____ secondary generalized

B. Subtype
   ____ tonic-clonic
   ____ tonic (stiffening)
   ____ clonic (jerking)
   ____ myoclonic
   ____ absences (stares)
   ____ atonic (drop or loss of tone)
   ____ infantile spasms

C. Side:
   ____ left
   ____ right
   ____ generalized
   ____ bilateral
   ____ unknown

D. Region:
   ____ frontal
   ____ occipital
   ____ parietal
   ____ temporal
   ____ unknown

1. Age seizures began: _______________________________________________________

2. Description: _____________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

3. Have seizures changed from when they started?  Yes  No
   If yes, please explain: ____________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

4. How often do they occur?
   ____ daily  ____ number per day
   ____ weekly  ____ number per week (doesn’t occur daily)
   ____ monthly  ____ number per month (doesn’t occur weekly)

5. Are there any things that seem to cause this seizure type to occur more often?
   ____ tired
   ____ lots of excitement
   ____ flickering lights  ____ reading
   ____ illness
   ____ stress
   ____ upset
   ____ watching TV or computer games
   ____ other: ______________________________________________________________

6. How does he/she behave after seizures? Please mark all that apply:
   ____ resume activity  ____ confused for awhile
   ____ sleep
   ____ become irritable
   ____ other: ______________________________________________________________
ETIOLOGY:
Onset due to (please also indicate age):

[ ] unknown [ ] encephalopathy
[ ] head injury [ ] brain mass/tumor
[ ] malformation [ ] infectious
[ ] other (please describe)___________________________

Has the child been diagnosed with:

[ ] Sturge Weber [ ] Tuberous Sclerosis
[ ] Landau Kleffner Syndrome [ ] Partial/Agenesis of Corpus Callosum
[ ] Cortical Dysplasia [ ] Encephalopathy
[ ] Schizencephaly [ ] Other ________________________________
[ ] Hydrocephalus
[ ] Lennox-Gastaut Syndrome

Previous epilepsy surgical evaluation?

Yes [ ] No [ ]

General Questions:

Have the seizures changed the way the child acts in any way? [ ] Yes [ ] No

Have grades in school gone down? [ ] Yes [ ] No

Does the child play or socialize less with friends? [ ] Yes [ ] No

Does the family understand the problems related to the seizures? [ ] Yes [ ] No

Have the seizures limited what the child wanted to do in any way? [ ] Yes [ ] No

What effect have the seizures had on the family life?

[ ] financial [ ] acting out with other children
[ ] emotional [ ] decrease in number of social activities
[ ] divorce or separation [ ] discipline problems with siblings
[ ] other ________________________________
SECTION XV: PREMATURITY AND NEWBORN INTENSIVE CARE ADDENDUM
Complete this section only if your child had complications surrounding birth

Newborn Intensive Care
Where: _____________________________________________________________
Dates _____________________________________________________________

DIAGNOSES: Please check all that apply
____ Bronchopulmonary Dysplasia
____ Pneumonia type: ________________________________
____ Retinopathy of prematurity grade: ________________________________
____ Intraventricular Hemorrhage right grade: ______ left grade: ______
____ Apnea and Bradycardia
____ Jaundice highest bilirubin level: ______
____ PDA (patent ductus arteriosus)
____ Congenital heart problems describe: ________________________________
____ Infections describe: ________________________________

Did your child receive:
____ Intubation
____ Oxygen
____ Surfactant
____ Antibiotics types: ________________________________
____ Chest tube when: ________________________________
____ Umbilical catheters when: ________________________________
____ Surgeries detail: ________________________________
____ Incubator when: ________________________________
detail: ________________________________

POST NEWBORN INTENSIVE CARE UNITY HISTORY
How old was the baby when he/she went home? ________________________________

Monitored? Yes No
Summarize: _____________________________________________________________

Home oxygen? Yes No
Age discontinued: __________________________________________________________

Neonatal follow up? Yes No
Dates of service: __________________________________________________________

Other history: _____________________________________________________________
________________________________________________________
________________________________________________________

Child Development & Neuropsychology Center
Developmental History Form; Rev 02/13
SECTION XVI: ADDENDUM: ACCIDENT/INJURY
Complete this section only if your child experienced accidents or illnesses that may have affected the brain or central nervous system

Date of accident/injury: _____________________________________________________

Details: ___________________________________________________________________
__________________________________________________________________________

Was the child taken to the emergency room? ____________________________
What is the name of the medical facility? ____________________________

What were the results of the medical evaluation? ______________________________________
____________________________________________________
__________________________________________________________________________

Immediately following the injury/illness, circle any behaviors which applied:

Agitated/Irritable Confused Combative (fighting) Unresponsive

Did your child experience a loss of consciousness? ____________________________
If yes, how long? ____________

Was your child comatose? ____________________________
Duration of coma: ____________

Glasgow coma scale (GCS) rating at scene? 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
Glasgow coma rating (GCS) at ER admission? 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

Did child receive:

___ Intensive Care Duration of ICU care ____________________________
___ Intubation Duration of intubation ____________________________
___ Extra ventricular drain or pressure bolt Duration of drain/bolt ____________________________

Did child receive rehabilitation services following the injury/illness?

Physical Therapy Speech Therapy Occupational Therapy

If so, where and what were the results of the therapy? ____________________________
__________________________________________________________________________

Diagnostic studies completed, check all that apply:

___ x-rays Specify: ____________________________ by: ____________________________
___ CT scan Specify: ____________________________ by: ____________________________
___ MRI Specify: ____________________________ by: ____________________________
___ EEG Specify: ____________________________ by: ____________________________
___ SPECT Specify: ____________________________ by: ____________________________
___ Angiogram Specify: ____________________________ by: ____________________________
___ Neurological evaluations
Date: ____________________________ by: ____________________________
___ Other, please explain: ____________________________
Does your child experience post-injury headaches?  
Yes  No

Frequency of headaches: ____________________________________________________________

Severity

mild  1  2  3  4  5  6  7  8  9  10  severe

Have sleep patterns changed?  
Yes  No
If yes, please describe: ____________________________________________________________

Which, if any, of the symptoms below has your child experienced since being injured?  
If symptoms were present before the injury, but changed after, please explain below.

____ Nausea  ____ Decreased attention
____ Vomiting  ____ Easily fatigued
____ Ringing in ears  ____ Decreased energy
____ Blurred vision  ____ Weight gain/loss
____ Aggression  ____ Difficulty with crowds
____ Sexually acting out  ____ Difficulty with noise/light
____ Fainting/blackouts  ____ Mood swings
____ Memory problems  ____ Hallucinations
____ Depression  ____ Easily overwhelmed
____ Pain  ____ Socially awkward
____ Anxiety  ____ Nightmares, Night terrors

Changes in:
____ Speech/language  ____ Vision
____ Reading  ____ Anger
____ Math skills  ____ Stress tolerance
____ Sense of smell  ____ Frustration threshold
____ Sense of taste  ____ Motor skills

Please provide any additional information that you feel may be of benefit in understanding the consequences of the injury?

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________