CDNC

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PEDIATRIC NEURODEVELOPMENTAL RE-EVALUATION HISTORY FORM

Thank you for taking the time to complete this form.
This information is essential to my being able to
conduct a thorough evaluation of your child.

_____

Child's Name

_____

Date Completed

_____

Person Completing Form

List professionals to who you would like this report to be sent to:

Name **Address** **Phone**

_____
_____
_____
_____
_____

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

Child's Full Legal Name _____

Birth Date _____ Current Age _____ Gender Identity_____ Preferred Pronouns_____

Current Grade _____ School _____ District _____

Child's Current School and District**:** _____

Please fill out the following questions as related to your child since their previous testing

Reason for referral/ What most concerns you about your child?_____
_____
_____
_____
_____
_____

Areas of improvement since last evaluation:_____
_____
_____
_____
_____
_____

Areas of continued difficulty:_____
_____
_____
_____
_____
_____

Any decline in skills?_____
_____
_____
_____
_____
_____

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

☑			☑	
	High activity			Sleep difficulties
	Acts as if "driven by a motor"			Daytime accidents
	Impulsivity (poor self-control)			Bedwetting
	Heedless to danger			Worried or anxious
	Interrupts frequently			Obsessions
	Poor attention span			Compulsive behavior
	Difficulty finishing tasks			Sad/depressed
	Easily distracted			Lack of interest in activities normally enjoys
	Disorganized			Irritability
	Loses things frequently			Often seems tired or fatigued
	Processing difficulties			Complains of pain, headaches, stomach aches
	Does not seem to listen			Changes in appetite
	Low frustration tolerance			Social withdrawal
	Excessive swearing			Does not think logically
	Unusually aggressive			Poor memory
	Temper outbursts			Gets lost easily
	Does not respond to discipline			Poor awareness of time
	Does not learn from consequence or experience			Problems understanding humor
	Clumsy/poor motor coordination			Problems finding the right word
	Socially awkward			Problems understanding directions
	Tics/unusual movements or sounds			Asks others to repeat what they've said
	Nervous habits			Sees, hears, or feels things that are not there
	Talking around issues, can't come to a point			Self-injury
	Does or says things over and over			Picky eater
	Has difficulty with change			Diet restriction
	Problems expressing emotions			Binging/purging

Has your child experienced any of the following problems currently or in the past?

___ Drugs/substance use	____ Violent behavior	____ Physical/sexual abuse (victim)
____ Alcohol use	____ Lying/cheating	____ Physical/sexual abuse (perpetrator)
____Cruelty to animals	____Legal issues/detention/arrests	____Emotional abuse
____ Actively rebelling	____ Inappropriate sexual behavior	____ Neglect
____ Vandalism/stealing	____ Suicidal threats/gestures	____ Trauma

____Other concerning behaviors? _____

_____

Does your child have any sensory differences (over- or under-sensitivity) to any of the following stimuli:

____visual/light:_____

____sound/noise:_____

____touch/textures:_____

____taste/smell:_____

Has your family experienced any of the following impacts on the family life as a result of your child's delays, behavioral/emotional concerns, psychiatric needs, and/or medical diagnoses?

____ financial ____ acting out with other children
____ emotional ____ decrease in number of social activities
____ divorce or separation ____ discipline problems with siblings
____other _____

DEVELOPMENTAL PROGRESSION

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 your child's hygiene appropriate for their age? Yes No
If no, please explain:_____
_____

How does your child do with being able to complete chores for their age? _____
_____
_____

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

If driving age, does your young adult have their driver's _____permit _____license
Any concerns?_____

REHABILITATIVE/DEVELOPMENTAL THERAPIES

Since their last evaluation, has your child received any private rehabilitative/developmental therapies?
(speech/language therapy, occupational therapy, physical therapy, vision therapy, music therapy, art therapy, etc.)

Type of therapy	Dates/Age range	Service Provider/Agency	Helpful?

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 _____

Does your child have a best friend? Yes No
Is your child different than their peers? Yes No
Please explain: _____
_____
_____

Please explain any problems with friendships: _____
_____
_____

Any difficulties with being:

____ Bossy	____ Initiating play	_____ Individual play
____ Compromising	____ Making new friends	_____ Group play
____ Sharing or taking turns	_____ Keeping old friends	_____ Imaginative play
____ Following the rules	_____ Withdrawn	_____ Repetitive play
____ Tolerating losing	_____ Disinterested in others	_____ Being accepted

What are the best things about your child? _____
_____
_____
_____

What are your child's areas of accomplishment? _____
_____
_____

What does your child most enjoy doing? _____
_____
_____

What does your child dislike doing? _____
_____
_____

Does your child participate in:

Sport activities?	Yes	No
Music or art activities/lessons?	Yes	No
Other extracurricular activities?	Yes	No

Please Describe: _____
_____

SCHOOL EXPERINCE /LEARNING PROBLEMS

To the best of your knowledge, at what grade level is your child currently performing in the following:

Reading _____ Spelling _____ Writing _____ Mathematics _____

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	

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

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

Has your child ever been in Title One Resource or Special Education placement (IEP)? Yes No

If yes, what is your child's classification(s) through Special Education:

Autism	Intellectual Disability	Emotional Disturbance
Developmental Delay	Hearing Impairment/Deafness	Other Health Impaired
Specific Learning Disability	Visual Impairment	Orthopedic Impairment
Speech-Language Impairment	Multiple Disabilities	Traumatic Brain Injury

Has your child ever had a 504 Plan developed? Yes No
****Please attach a copy of your child's IEP and/or 504 Plan.**

Does your child receive any of the following <u>in school</u>: (please circle)

Pull-out resource	Speech Therapy
Occupational Therapy	Physical Therapy
Adapted physical education	Counseling
Tutoring	Other _____

Does (or has) your child received <u>private</u> tutoring? Yes No
Explain: _____
_____

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

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

PRESENT MEDICAL STATUS

****Please attach all relevant medical records**

Pediatrician/family physician: _____

Current medical problems for which your child is being treated: _____

_____

_____

Has your child had any surgeries or hospitalizations since their previous evaluation? Yes No

Year of surgery	Procedure/Reason for Hospitalization	Outcome
_____	_____	_____
_____	_____	_____

Hearing

Does your child have any hearing problems? Yes No

Explain _____

Has your child received an audiological evaluation? Yes No

Date _____ Results _____

Vision

Has your child received an ophthalmologic evaluation/vision screening? Yes No

Date _____

Does your child have any vision problems? Yes No

Explain:_____

Sleep

What time does your child go to bed? _____

What time do they fall asleep? _____

What time do they wake up? _____

Do they 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 / Apnea	Talk in sleep
Sleepwalk	Night Terrors (how often?)	Nightmares (how often?)

Has your child had a sleep study? Yes No

Is there a family history of sleep disorders? Yes No

Headaches

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	

Special Equipment

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 ____ communication device
____ other _____

MEDICATION HISTORY

Please list all medications your child is currently prescribed, as well as any prescribed, but discontinued since their previous evaluation. Typically the child should be administered all regularly prescribed medications for testing. Please discuss with examiner if you have concerns or questions:

Medication	Prescribed by	Dosage	Date Started/Ended	Response/Side effects

Name of prescribing physician/psychiatrist:_____

On the average, how often does your child receive their 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

MENTAL HEALTH HISTORY

Since their last evaluation, has your child received outpatient psychotherapy/counseling? Yes No

If yes, please provide the following information:

Therapist(s):_____

Diagnosis/Concerns Treated:_____

_____

_____

Duration of Treatment: _____

Response to treatment/outcome: _____

_____

_____

Since their last evaluation, has your child ever received acute psychiatric care (inpatient, residential, day treatment, intensive outpatient)?

Yes No

If yes, what program(s) and when? _____

_____

_____

Since their last evaluation, has your family used in-home services (family perseveration, respite, in-home mental health)? Yes No

If yes, what program(s) and when? _____

_____

_____

Since their last evaluation, has your child received other psychological/developmental/neuropsychological testing? ****Please attach any test results available**.

Yes No

If yes, when and by whom? _____

_____

_____

FAMILY HISTORY

Any change in family structure/dynamics since previous evaluation?_____

_____

_____

_____

Describe any problems between patient and parents:_____

_____

_____

_____

Describe any problems between patient and siblings:_____
_____
_____
_____

Describe overall, general family relationships:_____
_____
_____
_____

Since your child's previous evaluation, have there been any abuse issues in the family? (neglect, emotional, physical, sexual) Yes No
Please explain briefly:_____
_____
_____
_____

For the child's biological relatives, is there any history of the following, including siblings, parents, grandparents, aunts/uncles, and cousins:

Mother's side of family
____Learning problems
____ Attention/concentration problems
____ Hyperactivity
____ Developmental Disability
____ Intellectual Disability
____ Autism Spectrum Disorder
____ Anxiety
____ Obsessive-Compulsive Disorder
____ Depression
____ Suicidality
____ Bipolar Disorder
____ Alcoholism/Drug Abuse
____ Seizure Disorder
____ Genetic Disorder
____ Head Injury
____ Other neurologic condition

Father's side of family
____Learning problems
____ Attention/concentration problems
____ Hyperactivity
____ Developmental Disability
____ Intellectual Disability
____ Autism Spectrum Disorder
____ Anxiety
____ Obsessive-Compulsive Disorder
____ Depression
____ Suicidality
____ Bipolar Disorder
____ Alcoholism/Drug Abuse
____ Seizure Disorder
____ Genetic Disorder
____ Head Injury
____ Other neurologic condition