CDNC

Child Development & Neuropsychology Center, Inc.
623 East 2100 South, Suite 103
Salt Lake City, UT 84106
p: 801-355-0195, f: 801-355-0199
www.cdnc-ut.com

PEDIATRIC NEURODEVELOPMENTAL 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

Child's Full Legal Name _____

Birth Date _____ Current Age _____ Gender Identity_____ Preferred Pronouns_____

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 contact 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 _____Divorced
_____ Married How long? _____ Date of divorce_____
_____ Cohabitating

Biological/Adoptive/Step/Foster Mother: _____ Age:_____
Education:
Highest grade/degree completed _____
Current employment _____Hours/wk _____

Biological/Adoptive/Step/Foster Father: _____ Age:_____
Education:
Highest grade/degree completed _____
Current employment _____Hours/wk _____

Adoptive/Step/Foster Parent/Guardian:_____ Age: _____
Education:
Highest grade/degree completed _____
Current employment _____Hours/wk _____

Adoptive/Step/Foster Parent/Guardian:_____ Age: _____
Education:
Highest grade/degree completed _____
Current employment _____Hours/wk _____

Additional children in the family:

Name Age Medical, social or school problems?

_____
_____
_____
_____
_____

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

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
(Complete only if your child was adopted)

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 their 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 completed Section XIV: Prematurity and Newborn Intensive Care Addendum)

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

Medication /Dose	Months Taken	Reasons for taking Medication

3. Was alcohol consumed during pregnancy? Yes No Unknown
If yes, how often and during which trimester(s):_____
_____

4. Was there smoking or tobacco used during pregnancy Yes No Unknown
If yes, how often and during which trimester(s):_____
_____

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

6. Were there any medical problems during pregnancy? Yes No Unknown
If yes, please describe:_____
_____

7. Were there any traumas/severe stress during pregnancy? Yes No Unknown
If yes, please describe:_____
_____

8. Delivery was: _____Vaginal _____C-section _____Forceps Used

9. Were there any problems with the labor or delivery? Yes No Unknown
If yes, please describe:_____
_____

10. Were any serious difficulties noted for the baby while in the hospital? Yes No Unknown
If yes, please complete Section XIV: Birth Injury, Prematurity, and Newborn Intensive Care Addendum

11. Did your child nurse? Yes No Unknown
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

What languages are spoken at home?_____

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
____ 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

Explanations:

____ Disrupted sleep
____ Difficult to calm/pacify
____ Irritability/easily agitated
____ Did not like to be held
____ Aggression
____ Thumb sucking
____ Nightmares
____ Clumsy/uncoordinated
____ Accident prone
____ 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 _____

Has your child received any private rehabilitative/developmental therapy (e.g., speech/language therapy, occupational therapy, physical therapy, vision therapy, music therapy, art therapy, etc.)?

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

Does your child receive DSPD Services? Yes No

Is your child: _____ Right-handed _____ Left-handed _____Ambidextrous _____Not yet sure
Age handedness became obvious? _____
Family history of left handedness? Yes No
Has your child ever changed handedness Yes No

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:_____

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?_____

SECTION VI: 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: _____
_____

SECTION VII: SCHOOL EXPERINCE /LEARNING PROBLEMS

Did/does your child receive Early Intervention (0-3 services)? Yes No
(***If so, please bring copy of IFSP)***

Schools Attended	Grades	Academic concerns?	Social/Behavioral concerns?
Preschool			
Kindergarten			
Elementary			
Middle/Junior High			
High School			

To the best of your knowledge, at what grade level is your child currently performing?
Reading _____ Spelling _____ Written Expression _____ Math _____

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

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

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?
_____
_____

SECTION VIII: CURRENT PROBLEM OR CONCERNS

Which specific behaviors interfere the most with your child's development and/or family functioning?
_____
_____
_____
_____
_____
_____

Check the behaviors that you believe your child **<u>currently</u> exhibits to an exaggerated degree** compared to siblings of 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			Word finding difficulties
	Socially awkward			Problems understanding directions
	Tics/unusual movements or sounds			Sees, hears, or feels things that are not there
	Nervous habits			Self-injury
	Talking around issues, can't come to a point			Picky eater
	Does or says things over and over			Diet restriction
	Has difficulty with change			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? _____

_____

_____

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 _____

Describe your approach to discipline with your child: _____
_____
_____

Is discipline effective? Yes No
Explain: _____
_____
_____

Have you taken any classes or read books on parenting skills? Yes No
____ Parenting with Love and Logic ____ Parent Effectiveness Training
____ 1-2-3 Magic ____ Other _____
____ SOS Help for Parents

SECTION IX: PRESENT MEDICAL STATUS

Pediatrician/family physician: _____

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

Any allergies? Yes No
If yes, please list:_____

Has your child had any surgeries or hospitalizations? 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?)

Is there a family history of sleep disorders? Yes No

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 _____

SECTION X: MENTAL HEALTH HISTORY

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: _____

_____

_____

Has your child ever previously received psychological/developmental/neuropsychological testing?

Yes No

If yes, when and by whom? _____

_____

_____

***Please attach any test results available**.

Has your child ever received acute psychiatric care (inpatient, residential, day treatment, intensive outpatient)?

Yes No

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

_____

_____

Have you used in-home services (family perseveration, respite, in-home mental health)?

Yes No

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

_____

_____

SECTION XI: MEDICATION HISTORY

Please list <u>all</u> 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:

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

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

SECTION XII: NEUROLOGICAL HISTORY

Please check all that apply to your child:

____ Birth Injury
____ Developmental disorder
____ Seizures
____ Meningitis
____ Encephalitis
____ Traumatic brain injury (TBI)
____ Skull fracture / concussion
____ Headaches (*see questions below)
____ Other _____

____ Spinal cord injury
____ Brain tumor
____ Tuberous Sclerosis
____ Cerebral palsy
____ Hydrocephalus
____ Encephalopathy
____ Genetic disorder
____ Metabolic disorder / Endocrine problems

If your child has had the following, please complete the noted addendums:

Seizures: Section XIII
Birth Injury/Prematurity: Section XIV
TBI/Head Injury/Concussion: Section XV

History of neurosurgery? Yes No

Condition/event	Dates of surgeries
_____	_____
_____	_____
_____	_____

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	

SECTION XIII: 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

- ____ tonic-clonic
- ____ tonic (stiffening)
- ____ clonic (jerking)

____ non-convulsive generalized

- ____ myoclonic
- ____ absences (stares)
- ____ atonic (drop or loss of tone)
- ____ infantile spasms

____ unclassified

____ status epilepticus

____ partial **(if type is "partial" then complete C and D. If not, continue on the next section)**

____ complex

____ secondary generalized

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

SECTION XIV: BIRTH INJURY, 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: _____
when: _____
____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: _____
_____
_____
_____

SECTION XV: ADDENDUM: TBI / HEAD INJURY / CONCUSSION / CNS INSULT
(Complete this section only if your child experienced a TBI, head injury, concussion, or 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? Yes No
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? Yes No
If yes, how long? _____

Was your child comatose? Yes No
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? (Please note provider/agency)
____Physical Therapy:_____
____Occupational Therapy:_____
____Speech/Language Therapy:_____
____Rehabilitative Therapy:_____
____Counseling:_____

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

Changes in:

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

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