CDNC

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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 _____
_____ Cohabitating

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:

Name Age Medical, social or school problems?

_____
_____
_____
_____
_____

***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.)

Mother's side of family

____Learning problems
____ School problems
____ Attention/concentration problems
____ Hyperactivity
____ Anxiety
____ Obsessive-Compulsive Disorder
____ Depression
____ Alcoholism/Drug Abuse
____Developmental Disability
____ Intellectual Disability
____ Autism/Pervasive Developmental Disorder
____ Bipolar Disorder
____ Seizure Disorder
____ Genetic Disorder
____ Head Injury
____ Metabolic Disease
____ Other neurologic condition

Father's side of family

____Learning problems
____ School problems
____ Attention/concentration problems
____ Hyperactivity
____ Anxiety
____ Obsessive-Compulsive Disorder
____ Depression
____ Alcoholism/Drug Abuse
____Developmental Disability
____ Intellectual Disability
____ Autism/Pervasive Developmental Disorder
____ Bipolar Disorder
____ Seizure Disorder
____ Genetic Disorder
____ Head Injury
____ Metabolic Disease
____ 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

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 completed 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)

Medication	Months Take (of 9)	Dose	Reasons for taking Medication

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? If yes, describe: Yes No

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
____ 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

Explanations:

____ 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 **<u>currently</u> 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
____ Temper outbursts
____ Clumsy/sloppy
____ Does not listen
____ Does not respond to discipline
____ Socially awkward/odd
____ A "different" child
____ Tics/twitching
____ Binging/Purging
____ Difficulty with sleep
____ Daytime accidents
____ Bedwetting
____ Worried or anxious
____ Gets lost easily
____ Poor memory
____ Does not think logically
____ Problems understanding jokes
____ Poor awareness of time
____ Problems expressing self
____ Talking around issues, can't come to a point
____ Does or says things over and over (perseveration)
____ Problems changing activities
____ Sees, feels, hears things that are not there
____ Sad, withdrawn or lonely
____ Pulling out own hair
____ Self-harm
____ Picky eater
____ Chewing/swallowing difficulties
____ Diet restriction
____ 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
____ 1-2-3 Magic
____ SOS Help for Parents
____ Parent Effectiveness Training
____ Other _____

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
____ Withdrawn
____ Disinterested in others
____ Initiating play
____ Making new friends
____ Keeping old friends
____ Group play
____ Compromising
____ Sharing
____ Being accepted
____ 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 EXPERINCE /LEARNING PROBLEMS

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

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

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
Sleepwalk	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

Program _____ Dates of attendance: _____

Has your child ever attended Residential or Day Treatment Programs? Yes No
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 <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

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
____ Headaches * see question below
____ Hydrocephalus
____ 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:

Name Specialty

1. _____
2. _____
3. _____
4. _____

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

SECTION XIII: OTHER RESOURCES

DSPD Services? Yes No
Caseworker _____ Phone number _____

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 duet 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
____ Landau Kleffner Syndrome
____ Cortical Dysplasia
____ Schizencephaly
____ Hydrocephalus
____ Lennox-Gastaut Syndrome
____ Tuberous Sclerosis
____ Partial/Agenesis of Corpus Callosum
____ Encephalopathy
____ Other _____

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

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: _____
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 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? 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?

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
____ 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?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____