Neuropsychology Intake Form

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Home Address: _____ City_____ ST ____Zip_____

Home Phone: _____ Name of person filling out this questionnaire: _____

Person who referred you: _____ May we thank this person? Y N

Referral Information

Problem Statement:_____

_____

_____

Describe your personal strengths: _____

_____

_____

Describe some of your personal weaknesses: _____

_____

_____

What do you hope to learn as a result of the evaluation? _____

_____

_____

Pregnancy and Birth History

Age of mother at delivery: _____ Age of father at delivery: _____

Known health problems of **mother** during pregnancy (circle all that apply)

Toxemia	Hypertension	Gestational Diabetes	Trauma
Fever	Allergies	Smoking	Alcohol Use
Drug Use	Antibiotics	Depression	Anxiety
Blood Incompatibility	Injury	Accidents	Emotional Abuse
Physical Abuse	Sexual Abuse	Spouses abuse:	Other:
Mental Illness	Sexually Trans. Disease	Other:	Other:

Please explain: _____

_____

List any medications, tobacco use, alcohol use, or drugs taken by mother during pregnancy: _____

_____

Delivery: Vaginal Cesarean If Cesarean, reason? _____

Full Term Premature

Weeks Gestation_____ Time spent in labor _____hours Birth Weight____ lbs. ____oz

Circle any birth complications that apply:

Feet first	Cord around neck	Meconium staining	Lacking oxygen
Jaundice	Not breathing	Other:	Other:

Explain: _____

Apgar scores: _____ How old were you at discharge from the hospital after birth? _____

Please explain any medical problems after discharge and interventions: _____

_____

Any problem in first few months? _____

Developmental History

Speech/Language:

First language _____ Language spoken in the home _____

Age spoke first word_____ Age put 2-3 words together (short sentences)_____

Circle all that apply to you as a child or currently:

Speech delays	Stuttering	Hard to Understand	Late Drooling
Poor Sucking	Poor Chewing	Articulation Problems	Slow to learn alphabet
Slow to learn colors	Slow to learn counting	Other: _____	Other: _____

Please list any speech therapy services you have received _____

_____

_____

Motor:

Age sat alone: _____ crawled: _____stood alone:_____ walked alone:_____

Were you slow to develop motor skills or awkward compared to siblings/friends (e.g., running, skipping, climbing, biking, playing ball?) Y or N Explain:_____

Handedness: Right Left Ambidextrous (both)

Family history of left-handedness (list relatives)? _____

Please list any physical or occupational therapy services your child has received _____

_____

Medical History

Has your vision been checked? **Y** or **N** Any problems: _____

Has your hearing been checked? **Y** or **N** Any problems: _____

CT or MRI Date obtained? _____ Results: _____

EEG Date obtained? _____Results:_____

Other tests and results:_____

List serious illnesses/injuries/hospitalizations/surgeries

Date	Incident (explain)
_____	_____
_____	_____
_____	_____

Circle all that apply to you in terms of your medical history:

Failure-to-thrive	Febrile seizures	Epilepsy	Staring spells
Head injuries	Meningitis	Encephalitis	Asthma
Allergies	Diabetes	Loss of Consciousness	Abdominal pains
Vomiting	Headaches	Ear infections	Sleep difficulties
Sleep walking or talking	Eating difficulties	Eating disorder	Facial or other Tics
Repetitive movements	Impulsivity	Temper tantrums	Nail biting
Clumsiness	Head banging	Self-injurious behavior	
Physical injuries	Lead poisoning/toxic ingestion		
Other: _____	Other: _____	Other: _____	Other: _____

Please explain the age of occurrence, relevant information, and interventions of any conditions circled above:

_____

_____

_____

Current medications and reasons: _____

Current physician and their address: _____

Psychological and Treatment History

(Circle all that apply)

Learning Difficulties	Mental Illness	Neurological Illness	Seizures
Psychiatric Disorder	Schizophrenia	Depression	Bipolar Disorder
Anxiety	Suicide	Alcoholism	Drug Abuse
Legal Problems	Arrests	Obsessive-Compulsive Disorder	Personality Disorder
Other: _____	Other: _____	Other: _____	Other: _____

Please explain:

_____

_____

_____

Is there a family history of mental illness?

_____

Social/Emotional History

Have you experienced (circle all that apply):

death of a loved one	separation from a loved one	emotional trauma	sexual abuse
family conflict	marital conflict	physical abuse	emotional abuse

Please explain_____

_____

_____

_____

Please list current and past psychologists, social workers, psychiatrists, counselors, outpatient and inpatient treatment, cognitive evaluations, neuropsychological evaluations, psychological testing, etc.

Name/ Occupation	**Dates Seen**	**For What?**	**Describe Progress**

Please add any additional information you would like us to know: _____

Social Behavior

Please explain any pertinent issues regarding your social behavior: _____

_____

_____

_____

_____

Does your make and maintain friendships? Y N Does you have any close friendships? Y N

Please explain: _____

_____

_____

_____

_____

_____

Have you ever had particular sensitivities (i.e., food, tags on clothing, etc.)? _____

_____

_____

_____

_____

Educational History

Current school and address: _____

Grade: _____ Placement: Gifted Regular Special Education (IEP)

Other_____

Any grades that were skipped? _____ repeated? _____

Teachers reported problems in: _____

_____

Reading	Spelling	Arithmetic	Writing
Attention	Behavior	Social Adjustment	Hyperactivity
Impulsivity	Easily Distracted	Other: _____	Other: _____

Please describe the above noted problem(s) _____

_____

_____

Grade:	Academic problems? (Please describe)
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever been evaluated for special education? Y or N (If yes please provide a copy of the evaluation)_____

_____

_____