Neuropsychology Intake Form

Patient/Child's Name: ____ Today's Date: _________________

Date of Birth: __________________ Age: _____

School: ____ Grade: ________________

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

Parent Information

Father: ____ Age:_______

Address (if different):____

Daytime Phone: _________________________ Cell Phone:___________________________________

Education: ______________________________Occupation: _________________________________

E-Mail ____

Mother: ____ Age:______

Address (if different):____

Daytime Phone: __________________________Cell Phone: ___________________________________

Education: ___________________________ ___Occupation: _________________________________

E-mail____ ___________________

Parents are: married separated divorced re-married deceased

Who has custody? ____

Sole Custody? Y N if yes, you must have legal documentation with you when you come.

Joint Custody? Y N We will need both parents' signatures before testing.

Referral Information

Problem Statement:____

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Describe your child's strengths: ____ ________

Describe some of your child's weaknesses: ______________________________

Do both parents agree about the nature and causes of the problem? ______________

If not, please explain: ______________________________

How do you discipline your child? ______________________________

What is the result? ______________________________

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

Child is: biological adopted (at what age); foster (how long?)

Does the child prefer one parent over the other? Y N Which one? ______________

Why? ______________________________

List Siblings and their ages: ______________________________

Others living in home: ______________________________

Is child in day care? Y N If so, how many hours/day? ______________

Pregnancy and Birth History

Age of mother at delivery: ____________________ Age of father at delivery: ____________________

Number of prior pregnancies: ____

Number of prior miscarriages: __________Was a fertility specialist consulted? ____________________

Living circumstances during pregnancy: ____

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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 next	Meconium staining	Lacking oxygen
Jaundice	Not breathing	Other:	Other:

Explain: ____

Apgar scores: __________ How old was baby at discharge from the hospital after birth? _____________

Please explain any medical problems after discharge and interventions: ___________________________

____

Any problem in first few months? ____

Did you experience postpartum (after birth) depression? _______________________________________

Developmental History

Speech/Language:

Child's first language ___________________ Language spoken in the home ______________________

Age spoke first word_______ Age put 2-3 words together (short sentences)________

Circle all that apply:

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 your child has received __________________________________

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Motor:

Age sat alone: __________ crawled: _________stood alone:_________ walked alone:___________

Was your child 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 ____________________

____

Toileting:

Age when toilet trained____

Problems with: Bedwetting Urinating Soiling Explain: ______________________

____

Any current problems? ____

____

Medical History

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

Has 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:

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:

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Current medications and reasons: ____

Child's Pediatrician and address: ____

Psychological and Treatment History

Family History (circle all that are present; include parents, siblings, aunts, uncles, maternal and paternal grandparents):

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:

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Does anyone else in the family have a problem similar to your child's reason for referral?______________

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Child history

Has your child 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____

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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

My child (circle all that apply)

Gets along with peers	Gets along with older children	Has a sense of humor	Gets along with adults
Keeps friends	Understands others' feelings	Understands social cues	Bullies others
Initiates play	Has problems with peer pressure	Is "bossy"	Is bullied by others
Is teased at school	Gets along with siblings	Initiates bad behavior	Has empathy for others

Please explain any pertinent issues regarding your child's social behavior: ________________________________

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

Please explain: ____

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Does your child have particular sensitivities (i.e., food, tags on clothing, etc.)? ____________________________

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Educational History

Current school and address: ____

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

Other____

Any grades that were skipped? ____________ repeated? ____________________________

Teachers report problems in: ____

____

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

Please describe the above noted problem(s) ____

____

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Grade:	Academic problems? (Please describe)
________	____
________	____
________	____
________	____

Has your child been evaluated for special education? Y or N (If yes please provide a copy of the evaluation____

____

____

Do teachers report problems that you do not notice? Y or N ___________________________

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Do you see problems that teachers don't notice? Y or N _____________________________

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