

CHILD/ADOLESCENT NEUROPSYCHOLOGY QUESTIONNAIRE

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The following is a detailed questionnaire about the child's development, medical history, and current functioning at home and at school. This information will be integrated with the testing results to provide a better picture of the child's abilities as well as any problem areas. Please fill out this questionnaire as completely as you can.

Child's Name: _____ Today's Date: _____
 Birthdate: _____ Age: _____
 Birth Country: _____ Age on arrival in country if born elsewhere: _____
 Person filling out this form: _____ Relationship to child: _____

What questions do you hope will be answered?

What Concerns Bring You Here?

Child's Family

Biological Mother's Name: _____ Age: _____ Highest Grade Completed: _____

Number of years of education: _____ Degree/Diploma (if applicable): _____

Occupation: _____

Biological Fathers Name: _____ Age: _____ Highest Grade Completed: _____

Number of years of education: _____ Degree/Diploma (if applicable): _____

Occupation: _____

Marital status of biological parents: Married Separated Divorced Widowed Other: _____

If biological parents are separated or divorced:

How old was this child when the separation occurred?

Who has legal custody of the child? _____

Stepparents' Name: _____ Age: _____ Occupation: _____

If this child is not living with either biological parents:

Reason: _____

Adoptive Parents Foster Parents Other Family Members Group Home Other: _____

Name(s) of legal guardians(s): _____

List all people currently living in the child's household

Name	Relationship to child	Age

If any brothers or sisters are living outside the home, list their names and ages:

Primary language spoken in the home: _____

Other languages spoken in the home: _____

If the child's first language is not English, please complete the following:

Child's first language: _____ Age at which the child learned English: _____

Current Medications

Medication	Reason Taken	Dosage (if known)	Start Date

Check the behaviors you believe the child exhibits to an excessive degree compared to other children his or her age.

- Nightmares
- Problems going to sleep
- Problems staying asleep
- Eats poorly
- Eats excessively
- Dangerous to self or others (describe):
- Purposely harms or injures self (describe):
- Talks about killing self (describe):

Check the behaviors you believe the child exhibits to an excessive degree compared to other children his or her age.

Social Development

- Prefers to be alone
- Very shy or timid
- Difficulty making friends
- Teased by other children
- Bullies other children
- Not sought out for friendship by peers
- Difficulty seeing another person's point of view
- Doesn't empathize with others
- Overly trusting of others
- Doesn't appreciate humor
- Unusual fears, habits or mannerisms (describe):
- Depressed
- Cries frequently
- Worried and anxious
- Overly preoccupied with details
- Overly attached to certain objects
- Not affected by negative consequences
- Drug abuse
- Alcohol abuse
- Sexually active

Behavior

- Stubborn
- Irritable, angry, or resentful
- Frequent tantrums
- Strikes out at others
- Throws or destroys things
- Lying
- Stealing
- Argues with adults
- Low frustration threshold
- Daredevil behavior
- Runs away
- Needs lots of supervision
- Impulsive (does things without thinking)
- Poor sense of danger
- Skips school

Other Problems

- Bladder control problems (not during seizures)
- Bowel control
- Motor/vocal tics
- Overreacts to noises
- Excessive daydreaming and fantasy life
- Problems with taste or smell

Motor Skills

- Poor fine motor coordination
- Poor gross motor coordination

Other problems: _____

Education Program

Where does the child go to school? _____ Grade: _____

Does your child have a modified learning program? Yes No

Is there an individual education plan (IEP)? Yes No

Are you satisfied with the child's current learning program? If not, please explain:

Has the child been held back a grade? No Yes If so, what grade(s)? _____

Is the child in any special education classes? No Yes. If yes, please explain:

Is the child in any special education classes? No Yes. If yes, please explain:

Is the child receiving learning assistance in or after school? No Yes. If yes, please explain:

Has the child ever been suspended or expelled from school? No Yes. If yes, please explain:

Has the child ever received tutoring? No Yes. If yes, please explain:

Please describe classroom or school problems, if applicable:

Rate the child's cognitive skills compared to other children of the same age

	Above Average	Average	Below Average	Severe Problem
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comprehension of Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problem solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remembering events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remembering facts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning from experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding concepts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall intelligence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check any specific problems

- | | |
|---|--|
| <input type="checkbox"/> Poor articulation | <input type="checkbox"/> Frequently loses belongings |
| <input type="checkbox"/> Difficulty finding words to express self | <input type="checkbox"/> Difficulty planning tasks |
| <input type="checkbox"/> Disorganized speech | <input type="checkbox"/> Doesn't foresee consequences |
| <input type="checkbox"/> Ungrammatical speech | <input type="checkbox"/> Slow thinking |
| <input type="checkbox"/> Talks like a younger child | <input type="checkbox"/> Difficulty with math/handling money |
| <input type="checkbox"/> Slow learner | <input type="checkbox"/> Poor understanding of time |
| <input type="checkbox"/> Forgets to do things | <input type="checkbox"/> Frequently forgets instructions |
| <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Poor articulation/speech defect |

Describe any other cognitive problems that the child has:

Describe any special skills or abilities that the child has:

Developmental History

During pregnancy, did the mother of this child:

Take any medication? Yes No. If yes, what? _____

Smoke? Yes No. If yes, how many cigarettes per day? _____

Drink Alcohol? Yes No. If yes, what did she drink and how much per day or week? _____

Use drugs? Yes No. If yes, what and how often? _____

List any complications during pregnancy (vomiting, staining/blood loss, threatened miscarriage, infections, toxemia, etc)

Duration of pregnancy (weeks): _____ Duration of labor (hours): _____ APGAR: _____ / _____

Were there any indications of fetal distress? Yes No. If yes, what? _____

Check any that apply to the birth: Labor induced Forceps Breech C-Section

If so, for what reason?

What was the child's birth weight? _____

Check any problems for the child after birth Jaundice Breathing problems Incubator Birth defects

If so, please describe:

Were there any other complications? Yes No. If yes, what ? _____
 Were there any feeding problems? Yes No. If yes, what ? _____
 Were there any sleeping problems? Yes No. If yes, what ? _____
 Were there any developmental problems? Yes No. If yes, what ? _____

Were any of the following present (to a significant degree) during infancy or the 1st few years of life?

- | | | |
|---|---|--|
| <input type="checkbox"/> Unusually quiet or active | <input type="checkbox"/> Colic | <input type="checkbox"/> Headbanging |
| <input type="checkbox"/> Did not like to be held or cuddled | <input type="checkbox"/> Excessive restlessness | <input type="checkbox"/> Constantly into everything |
| <input type="checkbox"/> Not alert | <input type="checkbox"/> Excessive sleep | <input type="checkbox"/> Excessive number of accidents |
| <input type="checkbox"/> Difficult to soothe | <input type="checkbox"/> Diminished sleep | |

Please indicate the approximate age at which the child first showed the following behaviors. Check "Never" if you child has never shown the behavior.

	Early	Average	Late	Never		Early	Average	Late	Never
Smiled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tied shoelaces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rolled over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dressed self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sat Alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fed self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder trained, day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder trained, night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Babbled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel trained	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First word	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rode tricycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sentences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rode bicycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical History

Vision problems No Yes (Describe: _____) Date of last vision exam: _____
 Hearing problems No Yes (Describe: _____) Date of last hearing exam: _____

Please a check next to any illness/condition the child has had, along with the approximate date or age of the illness.

Illness/Condition	Date(s)/age(s)	Illness/Condition	Date(s)/Age(s)
<input type="checkbox"/> Measles	_____	<input type="checkbox"/> Loss of consciousness	_____
<input type="checkbox"/> Attention deficit	_____	<input type="checkbox"/> Poisoning	_____
<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> Severe headaches	_____
<input type="checkbox"/> Chicken Pox	_____	<input type="checkbox"/> Rheumatic fever	_____
<input type="checkbox"/> Whooping cough	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Diptheria	_____	<input type="checkbox"/> Bone or joint disease	_____
<input type="checkbox"/> Scarlet fever	_____	<input type="checkbox"/> Sexually transmitted disease	_____
<input type="checkbox"/> Meningitis	_____	<input type="checkbox"/> Anemia	_____
<input type="checkbox"/> Encephalitis	_____	<input type="checkbox"/> Jaundice/hepatitis	_____
<input type="checkbox"/> High fever	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Seizures	_____	<input type="checkbox"/> Cencer	_____
<input type="checkbox"/> Allergy	_____	<input type="checkbox"/> High blood pressure	_____
<input type="checkbox"/> Hay fever	_____	<input type="checkbox"/> Heart disease	_____
<input type="checkbox"/> Injuries to head	_____	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Broken bones	_____	<input type="checkbox"/> Bleeding problems	_____
<input type="checkbox"/> Hospitalizations	_____	<input type="checkbox"/> Eczema	_____
<input type="checkbox"/> Operations	_____	<input type="checkbox"/> Physical abuse	_____
<input type="checkbox"/> Ear infections	_____	<input type="checkbox"/> Sexual abuse	_____
<input type="checkbox"/> Paralysis	_____	<input type="checkbox"/> Other	_____

Family Medical History *Check any problem that any family member has had*

Illness/Condition	Relationship to child	Illness/Condition	Relationship to child
<input type="checkbox"/> Seizures/epilepsy	_____	<input type="checkbox"/> Tics or Tourette's syndrome	_____
<input type="checkbox"/> Attention deficit	_____	<input type="checkbox"/> Alcohol abuse	_____
<input type="checkbox"/> Learning Disabilities	_____	<input type="checkbox"/> Suicide attempt	_____
<input type="checkbox"/> Mental Retardation	_____	<input type="checkbox"/> Physical abuse	_____
<input type="checkbox"/> Behavior Problems	_____	<input type="checkbox"/> Sexual abuse	_____
<input type="checkbox"/> Mental Illness	_____	<input type="checkbox"/> Parkinson's disease	_____
<input type="checkbox"/> Depression or Anxiety	_____	<input type="checkbox"/> Huntington's disease	_____
<input type="checkbox"/> Neurological disease	_____	<input type="checkbox"/> Antisocial behavior	_____

List any previous assessments the child has had:

	Dates of testing	Name of examiner
Psychiatric	_____	_____
Psychiatric	_____	_____
Neuropsychological	_____	_____
Educational	_____	_____
Speech pathology	_____	_____

List any form of mental health treatment the child has had (e.g., psychotherapy, family therapy, residential treatment)

Type of treatment	Dates	Name of therapist
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any recent stressors that might be contributing to the child's difficulties (e.g., illness, deaths, operations, accidents, separations, divorce, parent changed job, changed schools, family moved, family financial problems, remarriage, sexual trauma, other losses?)

Other Information

What are the child's favorite activities?

Has the child ever been in trouble with the law? Yes No. If yes, please describe:

On the average, what percentage of the time does the child comply with requests or commands? _____

Please describe the typical form of discipline for this child

What have you found to be the most satisfactory ways of helping the child?

What are the child's assets or strengths?

Is there any other information that may help me in assessing the child?