Edelson & Associates, P.S.C.

NEUROPSYCHOLOGICAL, PSYCHOLOGICAL & FAMILY SERVICES

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CHILD BACKGROUND INFORMATION

Directions: Your responses to this questionnaire are a very valuable part of the assessment process with your child. Please complete this form as thoroughly as possible. If you do not understand a question, ask the clinician working with your child to explain it at the time of the interview. Completion of this form before the interview is very important.

Today's Date _____

Person filling out questionnaire _____

Relationship to child _____

Address _____

_____

Preferred phone number _____

Primary language _____ **Secondary language** _____

PERSONAL DATA

Child's Name _____ **Birth Date** _____ **Age** _____

Address _____ **Sex M**_____ **F**_____ **Grade** _____

_____ **Handedness: Left** _____ **Right** _____

Phone _____

Primary language _____ **Secondary language** _____

Current School _____ **School Previous Year** _____

Teacher _____

REFERRAL INFORMATION

Who recommended our office to you?

What is your primary concern for your child?

When did these concerns begin?

What treatment/interventions have been tried?

Are there additional concerns?

When did these additional concerns begin?

What treatment/interventions have been tried?

What type of services are you seeking for the child (i.e., therapy, psychological testing, neuropsychological testing)?

CAREGIVER INFORMATION

With whom (which adults) does this child currently live? (please list all caregivers below)

Parent/Caregiver's Name____
Relationship to Child____
Address ______________________________________ **Age** ______________
Home phone _____________ **Work phone** _____________ **Cell phone** ________
Highest grade completed ______ **Language: Primary**_________ **Secondary** ________
Occupation ____
Employer ____ **How long?** ________
Child is in this caregiver's household what % of the time ______________________

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Parent/Caregiver's Name____
Relationship to Child____
Address ______________________________________ **Age** ______________
Home phone _____________ **Work phone** _____________ **Cell phone** ________
Highest grade completed ______ **Language: Primary**_________ **Secondary** ________
Occupation ____
Employer ____ **How long?** ________
Child is in this caregiver's household what % of the time _____

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Parent/Caregiver's Name____
Relationship to Child____
Address ______________________________________ **Age** ______________
Home phone _____________ **Work phone** _____________ **Cell phone** ________
Highest grade completed ______ **Language: Primary**_________ **Secondary** ________
Occupation ____
Employer ____ **How long?** ________
Child is in this caregiver's household what % of the time _____

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Parent/Caregiver's Name____
Relationship to Child____
Address ______________________________________ **Age** ______________
Home phone _____________ **Work phone** _____________ **Cell phone** ________
Highest grade completed ______ **Language: Primary**_________ **Secondary** ________
Occupation ____
Employer ____ **How long?** ________
Child is in this caregiver's household what % of the time _____

Does the child have any other parent(s) / stepparents(s) / guardian(s)? No_____ Yes____
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Please indicate:

Name _____ **Age** _____ **Relationship**_____

Address _____ **Home phone**_____

Name _____ **Age** _____ **Relationship**_____

Address _____ **Home phone**_____

CHILD CARE

If primary caregivers work outside the home, please provide the following information:

Who cares for this child when caregivers are gone? _____

_____

How many hours per day is this child in a child-care setting? _____

How many different people care for this child? (Please explain.) _____

_____

_____

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FAMILY INFORMATION

Language Spoken in the Home _____

Has this child ever experienced any parental separations, divorces or death? No __ Yes __

If yes, when? _____ **How old was this child at the time?** ____

Please describe the circumstances. _____

If parents are separated or divorced, how is custody arranged? _____

How often does each parent see this child? (check one)

__ **Weekly or more often** __ **Once or twice a month** __ **Few times a year** __ **Never**

Brothers / Sisters

Please list all brothers and sisters, and any other children living with the family.

Age	Sex	Relationship to this child	Living at home?

Family Relations

How well does this child get along with the primary caregiver(s)? _____

Activities enjoyed with caregiver(s)?_____

Is this child closer to one parent/caregiver than the other? No Yes If yes, which? ___

_____

How well does this child get along with brother(s) and/or sister(s)? _____
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Activities enjoyed with siblings? _____

How often does the child see grandparents? _____

How do they get along with grandparents? _____

What do you like best about this child? _____

What is the most difficult part about raising this child? _____

Who handles discipline? _____

What discipline techniques are used? _____

_____

Are discipline techniques effective? _____

Do caregivers agree on discipline? _____

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PREGNANCY

Number of previous pregnancies/miscarriages _____

Was this child a planned pregnancy? ___No ___Yes

Were there any concerns or issues during this pregnancy?

- ___**Gestational Diabetes:** _____
- ___**Early labor:** _____
- ___**Bleeding/Anemia/ High Blood pressure:** _____
- ___**Maternal injury:** _____
- ___**Rh incompatibility:** _____
- ___**Abnormal weight gain/loss:** _____
- ___**Illness/flu:** _____
- ___**Emotional Problems:** _____
- ___**Hospitalization during pregnancy:** _____
- ___**X-Rays during pregnancy: What month?** _____
- ___**Medications used during pregnancy: What kind?** _____
- ___**Alcohol used during pregnancy: Frequency** _____
- ___**Tobacco used during pregnancy: Type & Frequency** _____
- ___**Other substances (medication/drugs) used during pregnancy:**

Type	Frequency
_____	_____
_____	_____

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BIRTH

Biological mother's age at child's birth? _____ **Biological father's age?** _____

Was this child born in a hospital? Yes No If no, where? _____

Length of pregnancy: _____ **weeks** **Birth weight:** _____**lbs** _____**oz**

Length of labor: _____ **hours** **Apgar score** _____

Were there any complications that occurred during birth? (Please Check):

___Labor induced ___Cesarean delivery ___ Umbilical cord wrapped around neck/body

___Breech birth ___Forceps used

___Other delivery complications: ____

Child's health at birth ____

Were there any complications immediate after birth? (Please Check):

___Breathing problems ____

___Supplemental oxygen ___No ___Yes If yes, how long? _________

___Incubator: How long? ____

___Jaundiced: __No __Yes Required Bilirubin lights __No __Yes

If yes, how long? _________

Mother's health at birth ____

Was anesthesia used during delivery? ___No ___Yes If yes, what kind? _________

Length of stay in hospital: Mother: ________days Child: ________days

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DEVELOPMENT

At what age did this child first do the following? Please indicate year/month of age.

__________ Turn over

__________ Sit alone

__________ Crawl

__________ Stand alone

__________ Walk alone

__________ Run

__________ Focused on faces

__________ Showed awareness to sound

__________ Understand first words

__________ Speak first words

__________ Speak in sentences

Was this child breast-fed? No Yes When weaned? _________

Was this child bottle-fed? No Yes When weaned? _________

When was this child toilet trained? Days________________ Nights ________________

Did bedwetting occur after toilet training? No Yes How often? _____________

Did bed-soiling occur after toilet training? No Yes How often? _____________

Has this child experienced any of the following problems? If yes, please describe:

	During infancy and toddlerhood		*Currently*
Difficulty getting to sleep	No Yes	________________________	No Yes
Unable to sleep alone	No Yes	________________________	No Yes
Difficulty staying asleep	No Yes	________________________	No Yes
Early waking	No Yes	________________________	No Yes
Restlessness in sleep	No Yes	________________________	No Yes
Breathing difficulties in sleep	No Yes	________________________	No Yes

	During infancy and toddlerhood		*Currently*
Nightmares	No Yes	________________________	No Yes
Night terrors	No Yes	________________________	No Yes
Sleeping too much	No Yes	________________________	No Yes
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Sleeping too little	No	Yes	_____	No	Yes
Other sleep issues	No	Yes	_____	No	Yes
Feeding	No	Yes	_____	No	Yes
Underweight	No	Yes	_____	No	Yes
Overweight	No	Yes	_____	No	Yes
Colic	No	Yes	_____	No	Yes
Failure to thrive	No	Yes	_____	No	Yes
Selective in food choices	No	Yes	_____	No	Yes
Over eating	No	Yes	_____	No	Yes
Eating non-food items	No	Yes	_____	No	Yes
Other food issues	No	Yes	_____	No	Yes
Unclear speech	No	Yes	_____	No	Yes
Difficulty understanding others' speech	No	Yes	_____	No	Yes
Delay in onset of speech	No	Yes	_____	No	Yes
Stuttering	No	Yes	_____	No	Yes
Poor sentence construction	No	Yes	_____	No	Yes
Other speech issues	No	Yes	_____	No	Yes
Temper tantrums	No	Yes	_____	No	Yes
Separating from parents	No	Yes	_____	No	Yes
Excessive crying	No	Yes	_____	No	Yes
Poor behavioral regulation	No	Yes	_____	No	Yes
Difficulty with walking	No	Yes	_____	No	Yes
Difficulty with writing/ holding pencil	No	Yes	_____	No	Yes
Difficulty with using scissors	No	Yes	_____	No	Yes
Difficulty with using silverware	No	Yes	_____	No	Yes
Difficulty with throwing/catching ball	No	Yes	_____	No	Yes
Difficulty with pedaling bike	No	Yes	_____	No	Yes
Clumsiness / Balance problems	No	Yes	_____	No	Yes
Other motor skill issues	No	Yes	_____	No	Yes

Which hand does this child use for the following activities? (Please Circle)

Writing or drawing R / L Eating R / L Throwing R / L Catching R / L

Has this child been forced to change writing hand? No Yes

Date of most recent vision exam_____Current concerns regarding vision_____

Wears glasses or contacts: No Yes

Date of most recent hearing exam__________Current concerns regarding hearing________

Date of most recent speech exam__________Current concerns regarding speech________

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MEDICAL HISTORY

Childhood Illnesses/Injuries

Please check the illnesses this child has had and indicate age (year/month):

___Head injury: Describe____

___Coma or any loss of consciousness: Describe________________________________

___Sports injury / concussion: Describe____________________________________

___Sustained high fever: Describe____

___Seizures: Describe____

___Encephalitis____

___Meningitis________________________ ___Thyroid disorder__________________

___Measles__________________________ ___Rheumatic fever__________________

___German measles___________________ ___Diphtheria_______________________

___Mumps___________________________ ___Chicken pox______________________

___Tuberculosis______________________ ___Anemia__________________________

___Whooping cough___________________ ___Fever above 104º __________________

___Scarlet fever______________________ ___Broken bones_____________________

Please describe any other serious illnesses or operations:

Illness/Operation	Age

Has this child had any issues in the following areas (provide date & description):

Neurological:

Seizures/Convulsions No Yes ____

Speech defects No Yes ____

Memory No Yes ____

Problem solving No Yes ____

Tics/twitches No Yes ____

Head banging No Yes ____

Rocks back and forth No Yes ____

Other No Yes ____

Has this child ever had a neurological exam? No Yes

If yes, neurologist's name ________________________________ City _________
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Reason for exam _____

_____

Respiratory problems:

Recurrent cough	**No**	**Yes**	_____
Asthma	**No**	**Yes**	_____
Reactive airway	**No**	**Yes**	_____
Exercise induced	**No**	**Yes**	_____
Hay fever	**No**	**Yes**	_____
Sinus condition	**No**	**Yes**	_____
Other	**No**	**Yes**	_____

Cardiovascular problems:

Heart murmur	**No**	**Yes**	_____
Blood pressure	**No**	**Yes**	_____
Activity limitation due to heart condition	**No**	**Yes**	_____
Other	**No**	**Yes**	_____

Bowel / Digestive problems:

Excessive vomiting	**No**	**Yes**	_____
Frequent diarrhea	**No**	**Yes**	_____
Constipation	**No**	**Yes**	_____
Stomach pain	**No**	**Yes**	_____
Other	**No**	**Yes**	_____

Urinary problems:

Daytime accidents	**No**	**Yes**	_____
Nighttime accidents	**No**	**Yes**	_____
Pain while urinating	**No**	**Yes**	_____
Excessive urination	**No**	**Yes**	_____
Strong odor to urine	**No**	**Yes**	_____
Other	**No**	**Yes**	_____

Muscle problems:

Muscle pain	**No**	**Yes**	_____
Clumsy walk	**No**	**Yes**	_____
Poor posture	**No**	**Yes**	_____
Other	**No**	**Yes**	_____

Skin:

Frequent rashes No Yes _____

Eczema No Yes _____

Recurrent sores No Yes _____

Acne No Yes _____

Frequent bruising No Yes _____

Other No Yes _____

Allergies:

Environmental No Yes _____

Food No Yes _____

Medicines No Yes _____

Other allergies No Yes _____

_____

Primary Care Physician

Child's Physician _____ **Telephone** _____

How frequently does this child see this doctor? _____ **Date of Last Visit** _____

How often is this child treated at an Immediate Care Center or ER _____

Is this child currently taking prescription or over the counter (OTC) medication? No Yes

If yes, indicate type and reason _____

Has this child ever been on any prescription or OTC (homeopathic, supplements) medication for six months or more? No Yes If yes, when? _____ **What kind?** _____

Has this child ever taken tranquilizing or sleep medications? No Yes

If yes, when? _____ **What medication?** _____

Has this child ever taken medication for ADD, ADHD or similar problems? No Yes

If yes, when? _____ **What medication?** _____

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PSYCHOLOGICAL HISTORY

Has this child ever been in counseling or therapy for emotional or behavioral issues?

No Yes If yes, counselor's name _____

Address _____ **Telephone** _____

Type of counseling and when _____

_____

_____

Has this child ever had a psychiatric consultation or been through an intake interview?

No Yes If yes, doctor's name _____ **City** _____

Reason for exam _____

_____

Has this child ever been physically or sexually abused? No Yes

If yes, please discuss this issue with the clinician seeing your child.
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Please describe any current mental health diagnoses or concerns (i.e. depression, anxiety, ADHD)

Has this child ever made threats of self harm? No Yes

If yes, please discuss_____

Has this child ever made threats to harm others? No Yes

If yes, please discuss_____

Has this child ever saw or heard things that were not there? No Yes

If yes, please discuss_____

Behavior / Emotion / Temperament

Please describe your child's:

Mood_____

General demeanor_____

Level of anxiety _____

What makes this child angry? _____

How long does the child stay angry? _____

What makes this child anxious/fearful? _____

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FAMILY HEALTH

Have any family members, including parents, siblings, grandparents and aunts / uncles had any of the following? Please check and list whom?

___ **Cancer**_____	___ **Multiple Sclerosis**_____
___ **Diabetes**_____	___ **Kidney Disease**_____
___ **High Blood Pressure**_____	___ **Migraine Headaches**_____
___ **Heart Disease**_____	___ **Cluster Headaches**_____
___ **Stroke**_____	___ **Tourette's syndrome**_____
___ **Mitral Valve Prolapse**_____	___ **Severe Head Injury**_____
___ **Seizures or Epilepsy**_____	___ **Food Allergies**_____
___ **Alzheimer's** _____	___ **Thyroid Disorder**_____
___ **Hemophilia**_____	___ **Birth Defect**_____
___ **Huntington's Chorea**_____	___ **Sickle-Cell Anemia**_____
___ **Muscular Dystrophy**_____	___ **Cerebral Palsy**_____
___ **Parkinson's** _____	___ **Cystic Fibrosis**_____

Describe biological father's present health: _____

_____

Describe biological mother's present health: _____

_____

FAMILY MENTAL HEALTH

Have any family members, including parents, siblings, grandparents and aunts / uncles had any of the following? Please check and list whom?

___ **Depression**_____ ___ **Bipolar Disorder**_____
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___ **Anxiety/Nervousness**_____ ___ **Alcohol Abuse**_____

___ **OCD**_____ ___ **Drug Abuse**_____

___ **Though Disorders**_____ ___ **Behavioral Disorders**_____

___ **Personality Disorders**_____ ___ **Autism Spectrum Disorder**_____

___ **ADD/ADHD**_____ ___ **Other**_____

FAMILY EDUCATION

Have any family members, including parents, siblings, grandparents and aunts / uncles had any of the following? Please check and list whom?

___ **Reading Disability**_____ ___ **Speech or Language Problem**_____

___ **Math Disability**_____ ___ **Writing Disability**_____

___ **Mental Retardation**_____ ___ **Special Education**_____

___ **Other Disability**_____

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PEER RELATIONSHIPS

Does this child have problems forming friendships: No Yes

If yes, describe: _____

_____

Gets along well with peers (shares, etc.) No Yes _____

Fights often with peers/friends No Yes _____

Prefers to play with younger children No Yes _____

Prefers to play with older children No Yes _____

Is bullied by peers No Yes _____

Often plays alone No Yes _____

How many near age children are there in the neighborhood for this child to play with? ____

Can your child alternate between leading and following in play? _____

_____

HABITS / BEHAVIORS

Do you have reason to believe that your child is using or has experimented with any of the following?

Cigarettes	**No**	**Yes**	**Chew tobacco**	**No**	**Yes**
Inhale toxic substances (e.g., paint)	**No**	**Yes**	**Drink beer, wine or liquor**	**No**	**Yes**
Use illegal drugs (e.g., marijuana, cocaine)	**No**	**Yes**			

RECREATION / EXTRA CURRICULAR ACTIVITES

Sports: _____

Hobbies: _____

Other Interests: _____

Has this child's interest in participating in these activities declined recently? No Yes

If yes, describe. _____

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EDUCATIONAL HISTORY

Preschool and Daycare

Does or did this child attend preschool/daycare? No Yes At what age? _____

Amount of time per day _____ Days per week _____

Any problems in preschool? No Yes _____

_____

Does or did this child attend kindergarten? No Yes

Any problems in kindergarten? No Yes _____

_____

Elementary / Middle / High School

Elementary Schools Attended:_____

_____

Any problems in elementary school_____

Middle Schools / Jr. High Schools Attended:_____

_____

Any problems in middle school_____

High Schools Attended: _____

_____

Any problems in high school_____

If in high school, when will this child graduate? _____

Has your child changed schools more than is customary? No Yes

If yes, when and why? _____

Has your child been retained / failed a grade? No Yes

If yes, when and why? _____

Has your child been tested for special education? No Yes

If yes, when? _____

Does your child currently receive special education services? No Yes

If yes, what services are on the IEP? _____ Minutes per day ____

Does your child receive accommodation services through a 504 Plan? No Yes

If yes, what type of accommodations? _____

Does your child have a specialized behavior plan? No Yes

If yes, what behaviors is it for? _____

Has your child skipped a grade(s) in school? No Yes

If yes, when and why? _____

Has your child been tested for gifted / talented programs? No Yes

If yes, when? _____

Is your child currently in a gifted / talented class? No Yes

Does your child dislike going to school? No Yes

Is your child absent from school frequently? No Yes

If yes, why? _____

Do you have any concerns about the quality of this child's school or teachers? No Yes

If yes, describe. _____

Does your child have difficulty with reading? **No Yes**

If yes, describe. _____

Does your child have difficulty with math? **No Yes**

If yes, describe. _____

Does your child have difficulty with writing? **No Yes**

If yes, describe. _____

Does your child get poor grades **No Yes**

Describe your child's most recent report card. _____

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ADDITIONAL COMMENTS

_____

_____

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