

P 224.801.4514

# **Pediatric Neuropsychology - Parent Questionnaire**

### IDENTIFYING/DEMOGRAPHIC INFORMATION

Child's name:		Child's date of birth:					
Age <u>:</u> Gender:		Grade:	Ethnicity:	Handedness:			
Child's	s current addres	SS:					
Home/	cell phone num	ber <u>:</u>	School:				
Comm	unication:	Ok to leave pho	ne message Ok to tex	t message Ok to email			
Langu	age spoken at h	ome <u>:</u>					
Is child	d adopted?	If yes, at wha	atage				
Is chil	d currently livi	ing with both p	arents?				
If no,	with which par	ent is child livi	ng with now?				
Who h	nas legal custod	y of the child?					
•		_	with whom the child is 1	not living, please			
Mothe	r's name <u>:</u>		Work/Cell no	umber <u>:</u>			
Educa	tion/Occupation	ı <u>:</u>					
Mothe	r's email addres	ss <u>:</u>					
Father	's name:		Work/Cell no	umber <u>:</u>			
Educa	tion/Occupation	1:					
Father	's Email Addre	ss <u>:</u>					
Marita	al Status						
	Mother's:						
	Father's:						
Please	list all adults ar	nd children who	have regular contact with	your child:			
	Name	Age	Relationship to Child	Living in household?			



⊕ neuromindpsych.com

C 224.801.4514

### REFERRAL INFORMATION

Who referred you to our service?	
Name:	Profession:
Address:	
Phone number:	Fax number:
Primary Care Physician:	
Address:	
Phone Number:	Fax Number:
	REASON FOR REFERRAL
Briefly state the main concerns fo	or which you are presently seeking help for your child:
What kind of information or assi	stance are you hoping to obtain for your child?
Does the child have any school/le	arning problems? If yes, describe:
Does your child have any social p friends, poor social skills, aggressive,	bossy, shy, etc.):





meuromindpsych.com

C 224.801.4514

Please describe any other problems your child may have that may be of relevance to this evaluation:

Please describe two or three of your child's strengths:

Please describe two or three of your child's weaknesses:

Please list all past neurological, psychiatric, psychological, neuropsychological, educational, speech & language, or other types of evaluations administered to this child. (Indicate where, when, and by whom these were done).

Evaluated at	By Whom	When





☑ info@neuromindpsych.comℰ 224.801.4514

Please list all past or present interventions, treatment, or remediation the child has received or is receiving, including Physical Therapy, Occupational Therapy, Speech and Language Therapy, Psychotherapy, etc. (Indicate where, when, and by whom these were done.)

Received at	By Whom	When
	REGNANCY AND BIRTH HISTORY	
Describe any difficulties in conc pregnancy:	eption and/or complications th	at occurred during
Were any medications used duri	ing pregnancy?	If yes, what kind?
<b>Was alcohol, drugs, tobacco, or</b> If so, describe frequency and type:		pregnancy?
<b>Length of pregnancy</b> (months): <b>Type of delivery</b>	Number of weeks	<b>early</b> or

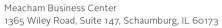


Any noteworthy issues during infancy?

Meacham Business Center 1365 Wiley Road, Suite 147, Schaumburg, IL 60173

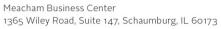
meuromindpsych.com

Complications during labor or deliver	y? (Please Describe below):
Birth weightlbsoz.	Number of days in the hospital:
Apgar scores (if known):	Did the baby require help to breathe?
Newborn difficulties:	
Other:	
DEVE As an infant, did your child show any o	ELOPMENT (INFANCY) eating or sleeping problems?
How would you describe temperament	t as an infant?





Developmental issues	Please describe
Speech/Language	
Sleeping Problems	
Toileting Problems	
Tics/twitches	
Nail biting, thumb sucking, grinding teeth	
Head banging/rocking	
Impulsivity	
Aggressive Behavior	
Temper Tantrums	





@ 224.801.4514

Anxiety/Fears/Worries			
Depression Crying	on/Sadness/		
			MILESTONES
Domain:	Child did the following:	Age:	Problems if any:
<b>Motor</b>	Sat without support		
	Crawled		
	walked		
	Toilet trained		
<b>Language</b>	Spoke first words		
	Put 2-3 words together		



⊕ neuromindpsych.com

@ 224.801.4514

	Spoke in sentences				
<b>Play</b>	Played with dolls/stuffed animals				
	Pretend/ima native play	ngi			
	Played in cooperation with other children				
			MEDICA	al History	
		Yes/No	Ages	Describe	
Allergie	s/asthma				
Appetite problem					
Clumsin motor sl	ness/poor kills				
Chromo Abnorm	somal/genetic aality				
Ear infe	ctions/tubes				





oxtimes info@neuromindpsych.com

Headaches		
Hearing/ear problems		
Loss of consciousness/head injury/ concussion		
Nightmares		
Persistent high fevers		
Physical disabilities		
Seizures		
Sleep problems, apnea/snoring		
Surgeries		
Vision/eye problems		
Alcohol use/abuse		



- ⊕ neuromindpsych.com
- P 224.801.4514

Illicit drug use/abuse		
Risky behaviors		

Please add any additional information about the above concerns:

Present illness for which child is being treated:

### **MEDICATIONS**

Medications (past/current)	Dosage	Prescribing physician

Notable childhood disease other than current illness (specify age and any complications):



⊕ neuromindpsych.com

Hospitalizations (medical or psychiatric):
Other issues/concerns regarding your child's health:
Family history of medical problems (light).
Family history of medical problems (list/describe):
Family history of attention/learning problems (list/describe):
Family history of emotional/behavioral/psychiatric problems (list/describe):



meuromindpsych.com

P 224.801.4514

## **EDUCATION HISTORY**

<u>Day Care</u>		
Does or did this child attend day car	re before preschool?	
Name:	Ages:	
Location:		
Any problems:		
Preschool		
Did this child attend preschool?		
Name:	Ages:	
Location:		
Any problems:		
Kindergarten  Did this child attend kindergarten?  Name:  Location:  Any problems:		
Elementary School/High School (Ple	ase list the names, locations, a	nd grades of schools attended):
Name	Location	Grades
Name of current school:		
Address of current school:		





Occupational Therapy ⊕ neuromindpsych.com

C 224.801.4514

Please indicate	the following, i	if applicable	e:		
Age child enter	ed 1 <sup>st</sup> grade <u>:</u>				
Retained a grad	de?	If yes,	when and why?		
Has your child	ever skipped	a grade in	school?	If yes, when and t	why?
Has your child	ever received (	detention, l	been suspende	d, or expelled?	If yes, describe:
Does or has you If yes, describe:		ed any spe	cial education,	enrichment, or r	esource service?
Services render	red under an I	EP or 504	Plan? Please	explain:	
Service	Yes/No	Ages	Describe		
Early Intervention (ages 0-3)					



- ⊕ neuromindpsych.com
- @ 224.801.4514

Physical Therapy			
Speech Therapy			
Social Work			
Please email			eports including formal IEP or 504 plans for us to nsive evaluation of your child.
Please check an	y of the stress	<mark>sful events th</mark>	at apply to your child or family and describe:
Relocations:			
☐ Job Change:			
Deaths:			
☐ Illnesses:			
☐ Marital Prob	lems:		



meuromindpsych.com

@ 224.801.4514

Traumatic Event:
Physical or sexual abuse or neglect:
Legal issues:
Other:
Please write any additional remarks you may wish to make regarding your child below.  The more information we have, the better we can help your child.



- meuromindpsych.com
- P 224.801.4514

#### **RATING SCALE: HOME VERSION**

Please check 1 box per item to select the number that best describes the child's behavior over the past 6 months (or since the beginning of the school year).

Never or Rarely 0	Sometimes 1	Often 2	Very often 3
	1	_	

From ADHD Rating Scale – 5 for Children and Adolescents: Checklists, Norms, and Clinical Interpretation by George J. DuPaul, Thomas J. Power, Arthur D. Anastopoulos, and Robert Reid. Copyright 2016 by the authors. Permission to photocopy this form is granted to purchasers of this book for personal use and use of individual clients (see copyright page details).