NeuroMind
Psychological Services 心理評估

Meacham Business Center
1365 Wiley Road, Suite 147, Schaumburg, IL 60173
neuromindpsych.com
info@neuromindpsych.com
224.801.4514

Pediatric Neuropsychology - Parent Questionnaire

IDENTIFYING/DEMOGRAPHIC INFORMATION

Child's name:_____ **Child's date of birth:**_____

Age:_____ **Gender:**_____ **Grade:**_____ **Ethnicity:**_____ **Handedness**:_____

Child's current address:_____

Home/cell phone number:_____ **School**:_____

Communication: **Ok to leave phone message** **Ok to text message** **Ok to email**

Language spoken at home:_____

Is child adopted? If yes, at what age_____

Is child currently living with both parents?

If no, with which parent is child living with now?

Who has legal custody of the child?_____

If you wish us to contact the parent with whom the child is not living, please give his/her name and address:_____

Mother's name:_____ **Work/Cell number**:_____

Education/Occupation:_____

Mother's email address:_____

Father's name:_____ **Work/Cell number**:_____

Education/Occupation:_____

Father's Email Address:_____

Marital Status

Mother's:

Father's:

Please list all adults and children who have regular contact with your child:

Name	Age	Relationship to Child	Living in household?

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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 for which you are presently seeking help for your child:

What kind of information or assistance are you hoping to obtain for your child?

Does the child have any school/learning problems? *If yes, describe:*

Does your child have any social problems with peers or adults *(e.g., bullied, teased, no friends, poor social skills, aggressive, bossy, shy, etc.):*

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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

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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

PREGNANCY AND BIRTH HISTORY

Describe any difficulties in conception and/or complications that occurred during pregnancy:

Were any medications used during pregnancy? *If yes, what kind?*

Was alcohol, drugs, tobacco, or other substances used during pregnancy?

If so, describe frequency and type:

Length of pregnancy (months):_____**Number of weeks early** _____or _____

Type of delivery

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Complications during labor or delivery? *(Please Describe below):*

Birth weight _____lbs. _____oz. **Number of days in the hospital**:_____

Apgar scores *(if known)*: _____ **Did the baby require help to breathe?**

Newborn difficulties:

Other:

DEVELOPMENT (INFANCY)

As an infant, did your child show any eating or sleeping problems?

How would you describe temperament as an infant?

Any noteworthy issues during infancy?

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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	

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Anxiety/Fears/Worries	
Depression/Sadness/ Crying	

MILESTONES

Domain:	Child did the following:	Age:	Problems if any:
Motor	**Sat without support**		
	Crawled		
	walked		
	Toilet trained		
Language	**Spoke first words**		
	Put 2-3 words together		

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	Spoke in sentences		
Play	**Played with dolls/stuffed animals**		
	Pretend/imaginative play		
	Played in cooperation with other children		

MEDICAL HISTORY

	Yes/No	**Ages**	**Describe**
Allergies/asthma			
Appetite/eating problems			
Clumsiness/poor motor skills			
Chromosomal/genetic Abnormality			
Ear infections/tubes			

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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			

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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):*

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Hospitalizations *(medical or psychiatric)*:

Other issues/concerns regarding your child's health:

Family history of medical problems *(list/describe):*

Family history of attention/learning problems *(list/describe):*

Family history of emotional/behavioral/psychiatric problems *(list/describe):*

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EDUCATION HISTORY

Day Care

Does or did this child attend day care 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:_____ **Ages**:_____

Location:_____

Any problems:

Elementary School/High School *(Please list the names, locations, and grades of schools attended):*

Name	Location	Grades

Name of current school:_____

Address of current school:_____

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Please indicate the following, if applicable:

Age child entered 1st grade:_____

Retained a grade? *If yes, when and why?*

Has your child ever skipped a grade in school? *If yes, when and why?*

Has your child ever received detention, been suspended, or expelled? *If yes, describe*:

Does or has your child received any special education, enrichment, or resource service?
If yes, describe:

Services rendered under an IEP or 504 Plan? *Please explain:*

Service	Yes/No	Ages	Describe
Early Intervention (ages 0-3)			
Occupational Therapy			

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Physical Therapy			
Speech Therapy			
Social Work			

Please email or bring copies of school reports including formal IEP or 504 plans for us to provide a comprehensive evaluation of your child.

Please check any of the stressful events that apply to your child or family and describe:

☐ Relocations:

☐ Job Change:

☐ Deaths:

☐ Illnesses:

☐ Marital Problems:

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☐ 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.

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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. Fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during activities.				
2. Fidgets with hands or feet or squirms in seat.				
3. Has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during conversations or lengthy reading)				
4. Leaves seat in situations in which remaining seated is expected.				
5. Does not seem to listen when spoken to directly				
6. Runs about or climbs in situations where it is inappropriate or feels restless				
7. Does not follow through on instructions and fails to finish schoolwork or chores.				
8. Unable to play or engage in leisure activities quietly (e.g., is unable to be or is uncomfortable being still for an extended period of time)				
9. Has difficulty organizing tasks and activities				
10. Is "on the go" or acts as if "driven by a motor."				
11. Avoids, dislikes or is reluctant to engage **i**n tasks (e.g., schoolwork, homework) that require sustained mental effort.				
12. Talks excessively.				
13. Loses things necessary for tasks or activities (e.g., school materials, pencils, books, glasses, phone, keys, wallet)				
14. Blurts out answers before questions have been completed				
15. Is easily distracted.				
16. Has difficulty waiting his or her turn.				
17. Is forgetful in daily activities.				
18. Interrupts or intrudes on others				