Child and Adolescent Neuropsychology

Child and Adolescent Neuropsychology, LLC
5100 Eden Avenue, Suite 109, Edina, MN 55436
952-388-7088 | CAN-Psych.com

Background Questionnaire

Child's name: ______________________________ Child's age: __________
Date of birth: ______________________________ Gender: __________
Address: ______________________________
City: ______________________ State: __________ Zip code: __________
Phone: ______________________

Name of person completing questionnaire: ______________________________
Is this evaluation being used for the purposes of a lawsuit: Yes No
If yes, please include lawyer's contact information: ______________________________

Parent/Guardian name: ______________________________ Age: __________
Address (if different from child's): ______________________________
City: ______________________ State: __________ Zip code: __________
Occupation: ______________________ Employer: ______________________
Phone: ______________________ Relationship to child: ______________________

Parent/Guardian name: ______________________________ Age: __________
Address (if different from child's): ______________________________
City: ______________________ State: __________ Zip code: __________
Occupation: ______________________ Employer: ______________________
Phone: ______________________ Relationship to child: ______________________

Parent/Guardian name: ______________________________ Age: __________
Address (if different from child's): ______________________________
City: ______________________ State: __________ Zip code: __________
Occupation: ______________________ Employer: ______________________
Phone: ______________________ Relationship to child: ______________________

Parent/Guardian name: ______________________________ Age: __________
Address (if different from child's): ______________________________
City: ______________________ State: __________ Zip code: __________
Occupation: ______________________ Employer: ______________________
Phone: ______________________ Relationship to child: ______________________

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Please list all people living in household:

Name	Relationship to child	Age

Primary language spoken in the home: _____

Other languages spoken in the home: _____

Have there been any major changes within the family life or the child's living situation that have affected your child's development (e.g., deaths, moves, divorces, loss of job, etc.)? No Yes (if yes, describe below)

Event	Date	Child's Age

If parents are separated or divorced, or child is in foster care:

Who has physical custody of the child? _____

Who has legal custody of the child? _____

What are the visitation or living arrangements? _____

Is the child adopted? Yes No

If yes, specify country of origin if international _____

Age when the child was first in home: _____ Date of legal adoption: _____

If the child was adopted, do they know they were adopted? Yes No

How many different foster care / adoptive placements has the child experienced? _____

What type of placements has the child experienced (e.g., orphanage, foster home, group home, shelter care, kinship home, hospitalization, etc.): _____

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Current concerns:

What are your main concerns about your child? Please provide examples when possible:

What are you hoping to achieve as a result of this evaluation?

What are your child's main strengths?

What is important for those involved in testing your child to know about him or her?

Pregnancy:

Did the child's mother receive prenatal care during the pregnancy? Yes No

Mother's age when she gave birth? _____

Did the mother have any of the following during or immediately before/ after the pregnancy (check all that apply)

____ Emotional problems	____ Abnormal weight gain	____ High blood pressure
____ Infections	____ Excessive swelling	____ Kidney disease
____ Preterm labor/ bedrest	____ Measles	____ Strep throat
____ Toxemia	____ Excessive vomiting	____ Threatened miscarriage
____ Anemia	____ Flu	____ Other virus

____ Other (Rh incompatibility, etc.): _____

____ Maternal injury. Describe: _____

Hospitalization during pregnancy? Reason: _____

Were any of the following used during pregnancy? (check all that apply)

____ Prescribed medications. (Please specify): _____ for: _____

____ Tobacco	____ Amphetamines	____ Cocaine
____ Marijuana	____ Heroin	____ Alcohol
____ Methamphetamines	____ Methadone	____ Other (specify) _____

Birth History:

Was infant born full term? Yes No Number weeks gestation _____

Birth weight: _____ lbs. _____ oz.

Type of delivery: ____ Uncomplicated ____ Cesarean ____ Induced (e.g. Pitocin)

____ Twins ____ Head first ____ Breech (feet first) ____ With instruments (forceps)

Describe any complications during delivery: _____

_____

Did your child have any medical issues at birth (e.g., seizures, jaundice, bleeding into the brain, cord around the neck, meconium aspiration, required oxygen)? Yes No

If yes, please describe: _____

_____

_____

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Developmental History:

Do you have concerns about your child's development? Yes No

If so, how old was your child when you began to have these concerns? _____

What were your concerns at that time? _____

_____

Cognitive Development:

Does your child do the things that other children his/ her age do? Yes No

Do you have concerns that your child's ability to think or learn is delayed? Yes No

Do you have any concerns about your child not acting his/her age? Please specify:

_____

Motor Development: (Please give the age each occurred)

Age rolled over: _____

Age sat alone: _____

Age crawled: _____

Age walked: _____

Which hand does your child use most? ____ Right ____ Left ____ No obvious preference

Do you have any concerns about your child's motor development? Please specify:

_____

Speech and Language: (Please give the age each occurred)

Age spoke single words: _____

Age spoke in 2-word phrases: _____

Age used sentences: _____

Difficulty with pronunciation? Yes No

Does child understand simple commands? Yes No

Do you have any concerns about your child's speech or language? Please specify:

_____

Hearing Concerns: Yes No If yes, please specify _____

Eating Behavior: ____ Normal ____ Picky ____ Eats too much ____ Weight loss/ gain

Oral Motor Concerns: ____ None ____ Difficulty swallowing ____ Drooling ____ Gagging

Has your child ever lost skills that at one time he/she was able to perform? Yes No

If yes, please explain: _____

Did your child have toileting accidents after toilet training? Yes No

If yes, please explain: _____

Infant/Toddler Behavior:

During this child's first 3 years, were any problems noted in the following areas?

____ Irritability
____ Colic
____ Difficulty sleeping/ feeding
____ Temper tantrums
____ Poor eye contact
____ Excessive crying
____ Withdrawn behavior
____ Destructive behavior
____ Unable to separate from parent
____ Hyperactivity
____ Other _____

As an infant and toddler, was your child interested in social contact (eye contact, social smile, showing things, sharing experiences)? Yes No

If no, please describe: _____

Child's Medical History:

Child's primary pediatrician:

Doctor's Name: _____ Clinic Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____

Has your child had a previous psychological/ psychiatric/ neuropsychological evaluation? Yes No

If YES, where was your child evaluated and by whom? _____

When? _____ **Please include a copy of that evaluation with this form.**

Has your child been given any medical or psychological diagnoses? If yes, please describe:

_____

_____

_____

Has your child ever had psychological counseling or therapy? Yes No

If yes, therapist's name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____

Type of therapy and for what issues _____

When? _____

Did you find it helpful? Yes No

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Has your child ever required occupational or physical therapy? Yes No

If yes, therapist's name _____

Address _____

City: _____ State: _____ Zip code: _____

Phone: _____

Type of therapy and for what issues _____

When? _____

Did you find it helpful? Yes No

Has your child ever been hospitalized in a psychiatric facility? Yes No

If yes, when? _____ Where? _____

Reason? _____

Has your child had any of the following tests or evaluations?

Test/Evaluation	*Yes*	*Date (month/ year)*	*Where*	*Results*
Neurologic Evaluation				Normal Abnormal Don't Know
CT scan of head				Normal Abnormal Don't Know
MRI scan of head				Normal Abnormal Don't Know
EEG				Normal Abnormal Don't Know
Audiology or hearing evaluation				Normal Abnormal Don't Know
Vision evaluation				Normal Abnormal Don't Know
Genetic Testing (chromosomes and/or DNA test for fragile X – please specify _____)				Normal Abnormal Don't Know
Other laboratory tests				Normal Abnormal Don't Know

Surgeries or hospitalizations: Age: _____ Reason: _____

Other details: _____

Major accidents or injuries: Age: _____ Type (head, abdomen, fracture, etc.) _____

_____

Does your child have any allergies? Yes No If yes, please explain:

_____

_____

What medications does your child take?

	Medication #1	*Medication #2*	*Medication #3*
Drug Name:			
Who Prescribes?			
For what problems?			
Dose:			
Date Started:			
Benefits:			
Side Effects:			

Family Medical History:

Mother: Health, learning, mental health problems? (please specify) _____

_____

Father: Health, learning, mental health problems? (please specify) _____

_____

Child's siblings: Health, learning, mental health problems? (please specify) _____

_____

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Have any family members had the following problems/ disorders?
Please specify the family member's relationship to the child.

	Specify Family Member(s)		Specify Family Member(s)
Birth defect		Reading problem	
Genetic disorder		Other learning disability	
Cerebral palsy		Speech/ language delay	
Severe head injury		Did not graduate from high school	
Migraine headaches		Cognitive Impairment	
Multiple sclerosis		Autism/ Aspergers/ PDD	
Physical handicap		Attention Deficit Disorder	
Tuberous sclerosis		Oppositional/ defiant behaviors	
Huntington's chorea		Antisocial behavior	
Muscular dystrophy		Aggression	
Sickle-cell anemia		Tics/ Tourette's Disorder	
Seizures or epilepsy		Nervousness/ anxiety	
Cancer		Obsessive-Compulsive Disorder	
Diabetes		Depression	
Heart Disease _		Bipolar/ manic depressive disorder	
Alcohol/ Drug abuse		Schizophrenia	
Physical/ sexual abuse		Other (specify)	

Have any family members ever received extra help in school, early intervention, or special education services?

Yes No If yes, specify who and the reason _____

_____

Child's Educational History:

Name of current school: _____ Phone Number _____

Teacher's Name: _____ Grade: _____

Does or did your child attend:

Early Intervention? No Yes At what age? _____ Name of School: _____

Preschool/ Head Start? No Yes At what age? _____ Name of School: _____

Other previous schools: _____

Has your child ever repeated a grade? No Yes If yes, what grade? _____

Does your child like going to school? No Yes

Has your child ever been suspended or expelled? No Yes Reason: _____

Is your child absent from school frequently? No Yes Reason: _____

School Assessments and Intervention:

****IMPORTANT: Please include copies of school testing reports and IEP with this form.****

Has your child had special education testing in school?

Psychological/ Cognitive	No	Yes	Date: _____
Academic	No	Yes	Date: _____
Speech/ Language	No	Yes	Date: _____
Other: _____	No	Yes	Date: _____

Is your child on an IEP (Individual Education Plan)? No Yes

If yes, for what reason? _____

Special Classes/ Services: Please check all that apply (specify what grade/ frequency/ duration)

Specific Learning Disability (SLD) _____

Emotional/ Behavioral Disability (EBD) _____

Autism Spectrum Disorder (ASD) _____

Speech/ Language Impairment (SLI) _____

Cognitive Disability (CD) _____

Occupational Therapy (OT) _____

Physical Therapy (PT) _____

Adaptive Physical Education (DAPE) _____

Other: _____

Does your child have a 504 Plan? No Yes

If yes, for what reason? _____

If your child is in school please, comment on the areas below:	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
Overall school performance					
Reading					
Writing					
Mathematics					
Relationship with teachers					
Relationship with peers					
Participation in organized activities (e.g., teams)					

Community Resources/ Social Services:

What, if any, community services have you been involved with?					
PCA care		Respite care		Parenting guidance	
Foster care		PACER		ARC	
Social worker		Other, please specify:			

Please provide the name and address(es) of anyone to whom you would like us to send a copy of the final report. We will also ask you to complete a formal Release of Information form before we mail anything.

_____

_____

_____

_____

_____

Thank you for taking the time to tell us about your child and family. This information will help us to prepare for your child's clinic visit and tailor our evaluation to best meet your child's needs.