

# Pediatric Neuropsychological Services of Alaska, PC

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## Pediatric Questionnaire

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of Evaluation: \_\_\_\_\_

Name of person completing questionnaire: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Who recommended that you seek an evaluation at this time? \_\_\_\_\_

### Reason for Seeking Evaluation

Current Problem *(use back of sheet if necessary)*

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Does the child have a medical condition, a neurological or developmental disorder, or a genetic syndrome?

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Does the child have any behavioral and/or emotional problems? \_\_\_\_\_

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Does the child have any learning or academic problems? \_\_\_\_\_

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Please describe the child's strengths. \_\_\_\_\_

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Please describe the child's weaknesses. \_\_\_\_\_

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Family History

(Please list as appropriate)

|            | <u>Age</u>  | <u>Gender</u> | <u>Birthweight</u> |
|------------|-------------|---------------|--------------------|
| This Child | _____ years | _____ (M/F)   | _____              |
| Brothers   | _____ years | _____ (M/F)   | _____              |
| and/or     | _____ years | _____ (M/F)   | _____              |
| Sisters    | _____ years | _____ (M/F)   | _____              |

Is this child: biological ? \_\_\_\_\_ adopted ? \_\_\_\_\_ a foster child ? \_\_\_\_\_  
 other family member (grandchild, niece/nephew)? \_\_\_\_\_

With whom does this child live at the present time? (Include parents, brothers, sisters, grandparents, friends, etc.)

\_\_\_\_\_

\_\_\_\_\_

What supports do you currently have in raising your children? CHECK ALL THAT APPLY

- Maternal grandparents     Paternal grandparents     Brothers/spouses  
 Sisters/spouses     Other relatives \_\_\_\_\_  
 Friends     Religious community     Community group(s)  
 Other \_\_\_\_\_

What language(s) is (are) used at home? \_\_\_\_\_

What is mother's education (highest grade completed)? \_\_\_\_\_ her occupation?

\_\_\_\_\_

What is father's education (highest grade completed)? \_\_\_\_\_ his occupation?

\_\_\_\_\_

Please list anybody in the family who is left-handed or mixed handed \_\_\_\_\_

\_\_\_\_\_

Please list anybody in the family who has had learning problems in school:

| <u>Person</u>  | <u>Problem</u>                                     |
|--|--|
| (parents, grandparents, brothers,<br>sisters, uncles, aunts, etc.) | (language, reading, writing, spelling, math, etc.) |
| _____  | _____  |
| _____  | _____  |
| _____  | _____  |
| _____  | _____  |

Please list anybody in the family who has had behavior problems:

Person

Problem (overactive, restless, withdrawn, difficulties with the law, etc.)

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Has anyone in the family ever been diagnosed with, or suffered from:

Seizures/epilepsy \_\_\_\_\_

Other neurological disease or disorder \_\_\_\_\_  
(brain injury, stroke, dementia...)

Emotional problems \_\_\_\_\_  
(anxiety, depression, bipolar disorder...)

Mental retardation/developmental disability \_\_\_\_\_

Birth History

Which (1<sup>st</sup>, 2<sup>nd</sup>, etc.) was this child of mother's pregnancies? \_\_\_\_\_

Age of mother at delivery \_\_\_\_\_ Age of father at delivery \_\_\_\_\_

Was this child born (check one):      premature \_\_\_\_\_ At the expected time \_\_\_\_\_ Late \_\_\_\_\_

Did your doctor note any problems with your pregnancy? labor? delivery? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medical History (Child)

Condition of child at birth \_\_\_\_\_

Did child have jaundice, "Rh" problems, chemical abnormalities, etc? \_\_\_\_\_

Has child had seizures, convulsions? \_\_\_\_\_ If so, at what age? \_\_\_\_\_

Were seizures/convulsions associated with a high fever? \_\_\_\_\_

Has child ever had a serious illness? If so, what? \_\_\_\_\_

When? \_\_\_\_\_ For how long? \_\_\_\_\_

Has child ever been hospitalized? If so, why? \_\_\_\_\_

When? \_\_\_\_\_ For how long? \_\_\_\_\_

Has child ever had any operations? If so, what? \_\_\_\_\_

When? \_\_\_\_\_

Does the child have any allergies? If so, what is s/he allergic to? \_\_\_\_\_

Has your child ever had any head injuries? If so, when? \_\_\_\_\_

What happened? \_\_\_\_\_

Was child unconscious? \_\_\_\_\_ dizzy? \_\_\_\_\_ Did child have a headache? \_\_\_\_\_

Was the child seen by a physician? \_\_\_\_\_

How often does child have abdominal pain/vomiting? \_\_\_\_\_

When does this occur? \_\_\_\_\_

How often does child have headaches? \_\_\_\_\_

How are these treated? \_\_\_\_\_

Does child have vision problems? (please specify) \_\_\_\_\_

Does child have hearing problems? (please specify) \_\_\_\_\_

Has child had a history of frequent ear infections? \_\_\_\_\_

If so, how often? \_\_\_\_\_ When? \_\_\_\_\_

**Please list all medications the child currently takes** \_\_\_\_\_

Developmental History:

As an infant, was this child fussy/difficult to comfort? \_\_\_\_\_ "sickly"? \_\_\_\_\_

over-sleepy/difficult to rouse? \_\_\_\_\_

Compared to other children, did this child have difficulty learning:

To talk? \_\_\_\_\_ To understand? \_\_\_\_\_

Gross motor skills (walking, talking, hopping, riding bike, etc.)? \_\_\_\_\_

Fine motor skills (fastening buttons, zippers, drawing, etc.)? \_\_\_\_\_

Early school related skills (colors, alphabet, etc.)? \_\_\_\_\_

To play/socialize with other children? \_\_\_\_\_

To build with blocks, play with puzzles, etc? \_\_\_\_\_

Has the child had difficulty in separating? \_\_\_\_\_ At what age? \_\_\_\_\_

When was the child toilet trained for day? \_\_\_\_\_ For nights? \_\_\_\_\_

Has this child had any sleeping difficulties? \_\_\_\_\_

Has this child had any eating difficulties? \_\_\_\_\_

Which hand does he/she prefer? for writing? \_\_\_\_\_ for sports? \_\_\_\_\_

When did s/he show a clear hand preference? \_\_\_\_\_

Does this child play with older, younger or same age children? \_\_\_\_\_

Does this child have the opportunity to play with children the same age? \_\_\_\_\_

Does this child have any hobbies, and/or participate in clubs, organizations, etc.? \_\_\_\_\_  
\_\_\_\_\_

What family responsibilities/chores does this child have? \_\_\_\_\_

Has this child ever had psychotherapy/counseling? \_\_\_\_\_

School History:

What grade is child presently in? \_\_\_\_\_ Has s/he ever repeated a grade? \_\_\_\_\_

Which? \_\_\_\_\_

What schooling, if any, did this child have prior to first grade? (please specify) \_\_\_\_\_  
\_\_\_\_\_

Did child have a pre-kindergarten screening? \_\_\_\_\_

If so, did he/she pass? \_\_\_\_\_

In which grade did school problems become noticeable? (where appropriate)  
\_\_\_\_\_

Has your child ever received special educational services in school? YES NO

If so, which grades? \_\_\_\_\_ What services have been provided? \_\_\_\_\_  
\_\_\_\_\_

Does your child currently have an Individualized Educational Plan? \_\_\_\_\_ or a 504 plan? \_\_\_\_\_ (check one)

Does child have resource room help now? YES NO

If so, for which academic skills? \_\_\_\_\_ how often? \_\_\_\_\_

Has child had frequent change of school? YES NO

If YES, why? \_\_\_\_\_

What is the child's present school? (please give full address)

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Who is the appropriate contact person for details of the child's schoolwork?

Name \_\_\_\_\_ Position \_\_\_\_\_

How long has s/he known the child/ \_\_\_\_\_

Is there any other information about the child and his/her family circumstances, development or medical condition that you would like the neuropsychologist to know?  
\_\_\_\_\_  
\_\_\_\_\_

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Health Care Insurance

Insurance Company \_\_\_\_\_

Contact Name & Number \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Address (*street, town, state, zip*)

\_\_\_\_\_ Best time to contact \_\_\_\_\_

Phone Number \_\_\_\_\_

Date \_\_\_\_\_

**Please bring any reports of psychological or educational evaluations that are available.**