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Diplomate of the American Board of Pediatric Neuropsychology
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INITIAL HISTORY

Name of child: _____ Date of Birth: _____

Address: _____

Home phone: _____ Cell: _____ email: _____

Parents' names: _____ Emergency contact: _____

Current school: _____ Grade: _____ Teacher: _____

School address and phone: _____

Who referred you? _____

Presenting problem(s)

When did this begin?

Other issues/concerns

Goals of this consultation

What are your child's strengths?

18321 Ventura Blvd., Suite 900
Tarzana, CA 91356
Neuropsychological Assessment
Consultation
Phone 818 705-4305
Fax 818 705-4307
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DEVELOPMENTAL HISTORY

1. Mother's health during pregnancy

a. Planned pregnancy? Y /N Wanted? Y /N

b. Mother's age when child was born

c. medications/alcohol/caffeine /tobacco

2. Delivery

a. gestational age (# of weeks of pregnancy at which child was born)

b. duration of labor medications during labor

d. fetal distress? APGAR scores at 1 minute? At 5 minutes?

e. baby's presentation (normal, use of forceps, vacuum)

f. birth weight

3. Baby's health

a. complications following birth time in NICU?

b. feeding problems

c. colic

e. health problems in infancy jaundice?

f. easy or difficult baby (schedule/crying)

g. degree of sociability? activity level?

4. Milestones - the age at which your child:

smiled sat without support crawled walked

spoke first words (other than mama/dada) phrases/sentences

What was your child's first language?

- other languages? Which ones and when learned?

Age of toilet training: bladder= bowel= Level of difficulty

5. Health Pediatrician:_____

a. overall

b. hearing and vision Is (s)he colorblind?

When was your child's last vision test? Who administered it?

c. fine motor coordination (writing/tying)

Does your child type/touch type?

d. gross motor coordination (running/walking/sports)

Is your child clumsy? Accident prone?

d. childhood illnesses/treatment

f. frequency/intensity of ear infections? strep throat?

g. high fevers/seizures/loss of consciousness/stitches/broken bones/poisoning/head injury

h. puberty status (girls age at first menses; boys voice change)

i. surgery general anesthesia for any other reason?

j. alcohol or drug use

k. sleeping problems? Snoring? Bedtime:
Wake up time:

l. medications (past and present; including current dosages)

m. Is/Was your child have hypersensitive to tactile sensations (mud, clothing labels, wool clothes, sock seams), light, sound?

n. appetite control problems? What does s/he eat?

Current height Current weight

7. School history of child (academic, social, performance. Include school names)

a. preschool - _____

b. elementary school - _____

c. junior high school - _____

d. high-school - _____

e. Does your child have a 504/IEP? If so, what accommodations/services does he/she receive?

What accommodations/service would you like him/her to receive?

f. tutors/educational therapists – Who? When? For what subjects?

8. Family constellation and quality of relationships

Married/Divorced/Separated/Widowed

Length of relationship

Quality of relationship Ever separated?

Previous marriages

Other children? How many? What ages?

Personality style of each child

Relationship between child in question and his/her siblings

Disciplinary practices and their effectiveness

How much time do you spend with your child on a daily basis?

Is religion a significant part of your family's life? Please describe.

Please describe the atmosphere of your home

Did/Do you have a nanny?

Hours of TV/week? Video games? TV in his/her room? Computer with internet??

Does your child have a cellphone?

What are your child's responsibilities around the house?

Where does s/he get spending money?

9. Social functioning

How's your child's social life?

How does your child prefer to spend his/her days?

9 Psychiatric history of child

a. psychotherapy – when and with whom?

b. traumas or major events in your child's life.

10. Parents' educational achievements

Mother:

Father:

Parents' type of work?

11. Handedness (left, right or ambidextrous)

of child? at what age did emerge? of siblings? of father? of mother?

father's parents and siblings? mother's parents and siblings?

11. Extended family medical history:

12. Extended family psychiatric history - any **close relatives** have:

a. aggression problems

b. attention problems

c. learning disabilities

e. psychosis

f. Physical/sexual abuse

g. substance-abuse

h. tics

i. depression

j. anxiety

k. mental retardation

l. obsessive thoughts

m. compulsive behaviors

n. bipolar disorder ("manic depression")

o. genetic disorder

p. autism/Asperger's Disorder

13. Supplementary information – anything else you want to include

14. If there are people with whom you are working that would be useful sources of information (e.g. psychiatrist, psychotherapist, occupational therapist, speech and language therapist, etc), please put their names and telephone numbers below. I will not contact any of them without your signed consent, but having the information here will make this process more efficient.

_____

_____

_____

If you are submitting for reimbursement to an insurance company, I may be contacted in the future to provide information to them to help them make decisions about your claim. Sign and date here if you authorize me to release information to the insurance, which may include the neuropsychological report and associated scores.

Yes, I authorize Dr. Chidekel to release all information requested by the insurance company in the service of pursuing reimbursement for my claim:

_____

Name Date