

Diplomate of the American Board of Pediatric Neuropsychology Diplomate of the American Board of Professional Neuropsychology

CHILD INITIAL HISTORY

Name of Child:	Date of Birth:
Mom phone:	Mom email:
	Dad email:
Current School:	Grade:
Teacher/counselor (Name and Email0:	
Who referred you?	
Presenting problems (and when they began)?	
Other issues/concerns?	
Goals of this consultation/assessment?	
What are your child's strengths?	

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Psy 14261

HISTORY

- 1. Mother's health during pregnancy
 - a. Planned pregnancy? Y/N Mother's age when child was born?
 - b. Mother's health?
 - c. Medications/alcohol/caffeine/tobacco?_____
- 2. Delivery
 - a. Gestational age?_____Birth weight?_____
 - b. Birth complications? Y/N_____ Fetal distress? Y/N _____
 - c. APGAR score 1 minute?____At 5 minutes?____Time in NICU? Y/N_____

3. Infant's health

a. Was baby nursed? Y /N If yes, when was (s)he weaned?_____

b. Any feeding problems? Y/N _____

- c. Jaundice? Y/N Colic? Y /N Health problems?
- d. Easy or difficult baby (schedule/crying)?_____
- e. Sociability? _____ Activity level?_____
- 4. <u>Milestones the age at which your child</u>:

Smiled?	_Sat without support	?Crawled?_	Walked?

Spoke first words? (other than mama/dada) _____Used phrases/sentences?_____

Child's first language?	Other languages?

Prior physical/occupational/speech therapy?_____

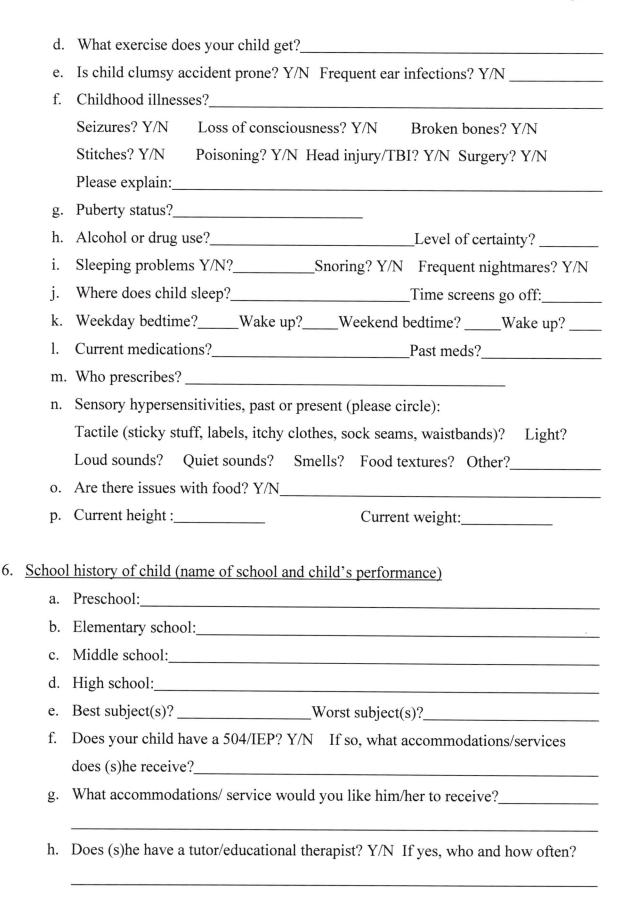
Age of toilet training: Bladder?____Bowel?___Level of difficulty?_____

- 5. <u>Health</u> Pediatrician: ______ Specialists: _____
 - a. Overall health? _____ Hearing? ____Vision? ____Colorblind? Y/N

b. Fine motor coordination (writing/tying/using scissors)?_____

c. Gross motor coordination (running/walking/sports)?_____

Child Initial History, 3



7.	Family constellation and quality of relationships
	Married/ Divorced/ Separated/ Widowed?Length of relationship?
	Quality of relationship:
	Other children? If so, please indicate names, ages and your child's relationship with each:
	Local family members?
	Disciplinary practices used at home?
	Time spent with child each day?Atmosphere at home:
	Hours of TV/week?Video games? Which ones:
	Does (s) have a cellphone? Y/N TV in his/her room? Y/N Computer with internet? Y/N
	Child's household responsibilities?
	Does (s) need prompts? Y/N Does (s)he cooperate? Y/N Do a good job? Y/N
8.	Social functioning
	How's your child's social life?
	What does (s)he like to do?
	(For teens) Does (s)he drive?Work?
0	
9.	Psychiatric history of child
	a. Traumas/major events in your child's life:
	b. Has (s)he had psychotherapy? Y/N If yes, when and with whom?
10	Parents' Educational/Work
- • •	Mother's education:
	Father's education:
	Parents' type of work?

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1	1.	Family	handedness	(left,	right	or	ambidextrous))

Child? _____Siblings? _____

Father? _____Father's parents? _____Father's Siblings? _____

Mother? _____ Mother's parents? _____ Mothers Siblings? _____

12. Extended family (close relatives) medical history

Paternal

Maternal_____

13. Extended family psychiatric history - Close relatives with diagnosed or undiagnosed:

- a. Aggression problems?_____
- b. Attention problems?_____
- c. Learning disabilities?_____

d. Psychosis/schizophrenia?_____

e. Physical sexual abuse?_____

f. Substance-abuse?_____

g. Tics/Tourette Syndrome?_____

- h. Depression?_____
- i. Anxiety?_____
- j. Obsessions/Compulsions?_____

k. Eating Disorder?_____

1. Intellectual disability ("Mental Retardation")?_____

- m. Bipolar disorder ("Manic Depression")?_____
- n. Autism Spectrum/Asperger's Disorder?_____
- o. Genetic disorder?_____
- p. Personality disorder?_____

14. Supplementary information - anything else you want to include?