PEDIATRIC NEURODEVELOPMENTAL HISTORY FORM

RE-EVALUATION FORM

____
Child's Name

____
Date Completed

____
Person Completing Form

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WASATCH PEDIATRIC NEUROPSYCHOLOGY
RE-EVALUATION HISTORY FORM

PLEASE HELP US KEEP OUR RECORDS UPDATED BY COMPLETING THE FOLLOWING INFORMATION

Current Address:____

____

Current Phone:____

Current Insurance Coverage:

Name of Company:____

Employer:____

Name of Insured: ____

Policy Number: ____

List professionals to who you would like this report to be sent to:

Name Address Phone

____
____
____
____

Please fill out the following questions as related to your child since your child's previous testing

Reason for referral/who referred?

What most concerns you about your child?

Areas of improvement since last evaluation:

Areas of continued difficulty:

Any decline in skills?

Check the behaviors that you believe your child **currently exhibits to an exaggerated degree** compared to siblings or other children of the same age:

____ High activity
____ Impulsivity (poor self-control)
____ Interrupts frequently
____ Poor attention span
____ Acts as if is "driven by a motor
____ Heedless to danger
____ Difficulty finishing tasks
____ Disorganized
____ Accident prone
____ Low frustration tolerance
____ Excessive swearing/inappropriate language
____ Unusually aggressive
____ Temper outbursts
____ Clumsy/sloppy
____ Does not listen
____ Does not learn from consequences
____ Does not benefit from experience
____ Does not respond to discipline
____ Socially awkward/odd
____ A "different" child
____ Tics/twitching
____ Hypersensitive touch/sound/sight/taste/smell
____ Hypo sensitive touch/sound/sight/taste/smell
____ Difficulty with sleep
____ Daytime accidents
____ Bedwetting
____ Worried or anxious
____ Gets lost easily
____ Poor memory
____ Does not think logically
____ Problems understanding jokes
____ Poor awareness of time
____ Problems expressing self
____ Talking around issues, can't come to a point
____ Does or says things over and over (perseveration)
____ Problems changing activities
____ Sad, withdrawn or lonely
____ Sees, feels, hears or smells things that are not there
____ Pulling out own hair
____ Self-harm
____ Picky eater
____ Chewing/swallowing difficulties
____ Binging/Purging
____ Diet restriction
____ Other concerning behavior

Is your child experiencing any of the following problems?

____ Drugs/substance abuse
____ Alcohol
____ Cruelty to animals
____ Actively rebelling
____ Vandalism/stealing
____ Violent behavior
____ Lying/cheating
____ Suicidal threats/gestures
____ Legal issues/arrest/detention
____ History of sexual abuse (victim)
____ History of sexual abuse (perpetrator)
____ Inappropriate sexual behavior
____ Pornography

Any specific behaviors that interfere with development or family functioning?

Problems with friendships? YES NO Explain____________________________________
Is well-liked by peers? YES NO Explain ____________________________________
Different form peers? YES NO Explain ____________________________________

Are Friends: older _____ younger _____ same age _____

Briefly describe specific problems with peers

Child's Current School and District:

Current Grade

To the best of your knowledge, at what grade level is your child currently performing?

Reading __________ Spelling __________ Arithmetic __________ Writing __________

Does (or has) your child received private tutoring?

YES NO

Please bring copies of the results.
Has there been any other forms of testing since the last evaluation? YES
NO Please bring copies of the evaluation.
How much time is spent each night doing homework with your child?

Has/have your child's classroom teacher(s) reported any of the problems below?

_____Attention/concentration
_____Few friends
_____Following directions
_____Distractibility
_____Doesn't get along well
_____Math problems
_____Hyperactivity
_____Bothering other students
_____Handwriting
_____Low energy
_____Behavior problems
_____Reading/Spelling problems
_____Withdrawal
_____Aggression
_____Not turning in assignments
_____Anxious
_____Oppositional
_____Poor memory
_____Other______________
_____Other______________

Any medical issues since previous testing? (Describe)

Please list all medications your child is currently taking and the dosage:

Any other information relevant since previous evaluation?