WASATCH PEDIATRIC
NEUROPSYCHOLOGY

PEDIATRIC NEURODEVELOPMENTAL HISTORY FORM

_____

Child's Name

_____

Date Completed

_____

Person Completing Form

Wasatch Pediatric Neuropsychology
www.kidsneuropsych.com

Julien Smith, Ph.D.
Lara Leishman, Ph.D.
Erin Krauskopf, Ph.D.
Pediatric Neuropsychologists

Heidi Mucha, Ph.D.
Laura Rowley, Ph.D.
Pediatric Psychologists

Child's Full Legal Name _____

Gender _____ Preferred Pronouns_____ Birth Date _____ Current Age _____

Current Grade _____School _____ District _____

Child presently lives with:

_____ Biological Parents _____ Biological Mother _____ Father/Step Parent
_____ Biological Father _____ Mother/Step Parent
_____ Adoptive Parent(s) _____ Foster Parents _____ Other_____

Referred by _____

Reason for referral: _____
_____
_____

What most concerns you about your child? _____
_____
_____

What are you hoping to learn and understand about your child by having an evaluation completed?
_____
_____
_____
_____

What changes are you hoping to make (or what development are you hoping to encourage) in your child by having this evaluation? _____
_____
_____
_____

Pediatrician/family physician: _____
Address/phone number: _____

List any professionals to whom you would like the final report sent:

Name Address Phone/Fax

_____
_____
_____
_____

- **Please sign release of information for each party to whom you want information released**

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196

SECTION I. FAMILY AND SOCIAL HISTORY

Marital status of primary caregiver(s):

_____ Single _____ Separated How long? _____
_____ Married How long? _____ _____ Divorced How long? _____
_____ Cohabitating How long? _____

Biological Mother: _____ Age:_____
Education:
Highest grade completed _____ (1-12) High school graduate/GED (circle one)
Attended college _____Highest degree awarded _____
Vocational Training _____Years _____
Current employment _____Hours/wk _____

Biological Father: _____ Age:_____
Education:
Highest grade completed _____ (1-12) High school graduate/GED (circle one)
Attended college _____Highest degree awarded _____
Vocational Training _____Years _____
Current employment _____Hours/wk _____

Adoptive/Step/Foster Parent:_____ Age: _____
Education:
Highest grade completed _____ (1-12) High school graduate/GED (circle one)
Attended college _____Highest degree awarded _____
Vocational Training _____Years _____
Current employment _____Hours/wk _____

Adoptive/Step/Foster Parent:_____ Age: _____
Education:
Highest grade completed _____ (1-12) High school graduate/GED (circle one)
Attended college _____Highest degree awarded _____
Vocational Training _____Years _____
Current employment _____Hours/wk _____

Additional children in the family (please include step/half siblings):

Name Age Medical, social or school problems?

_____
_____
_____
_____
_____

What languages are spoken in the home? _____

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196

For the child's biological relatives, mark who has a history of the following?
M = Mother, F = Father, S = Sister, B = Brother, GM = Grandmother, GF = Grandfather, U = Uncle, A = Aunt, C = Cousin

Mother's side of family
___Learning/School problems
___ Behavior problems
___ Attention/concentration problems
___ Hyperactivity
___ Anxiety
___ Obsessive-Compulsive Disorder
___ Depression
___ Alcoholism/Drug Abuse
___Developmental Disability
___ Intellectual Disability
___ Autism/Pervasive Developmental Disorder
___ Bipolar Disorder
___ Psychotic/Thought Disorder
___ Seizure Disorder
___ Genetic Disorder
___ Head Injury
___ Metabolic Disease
___ Other neurologic condition

Father's side of family
___Learning/School problems
___ Behavior problems
___ Attention/concentration problems
___ Hyperactivity
___ Anxiety
___ Obsessive-Compulsive Disorder
___ Depression
___ Alcoholism/Drug Abuse
___Developmental Disability
___ Intellectual Disability
___ Autism/Pervasive Developmental Disorder
___ Bipolar Disorder
___ Psychotic/Thought Disorder
___ Seizure Disorder
___ Genetic Disorder
___ Head Injury
___ Metabolic Disease
___ Other neurologic condition

Have any of your child's biological relatives experienced problems similar to those your child is currently experiencing? If so, please describe

_____
_____
_____

SECTION II: ADOPTION ADDENDUM

Age at adoption: _____ Country/state of birth: _____
Is this an open adoption? Yes No If yes, briefly explain: _____
_____
_____

Any failed adoptions? Yes No If yes, list reason _____
_____
_____

Foster placements? Yes No Please list approximate length of each placement
_____
_____

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196

Please describe any concerns related to your child's adjustment to his/her adoption:

_____

_____

_____

Please check all that apply to your adopted child:

____ Difficulty with bonding/attachment
____ Difficulty with eye contact
____ Social Withdrawal
____ Over-friendly with strangers
____ Better behaved outside the home
____ Excessive reaction to minor events
____ Indifferent to family members

SECTION III: PSYCHOSOCIAL HISTORY

Describe fathers and/or step/foster father's personality:

Describe fathers and/or step/foster father's relationship with patient:

Describe mothers and/or step/foster mother's personality:

Describe mothers and/or step/foster mother's relationship with patient:

Do you and your partner/other caregiver agree on the parenting style for this child? Yes No
Please explain briefly:

Describe any problems between patient and siblings:

Describe overall, general family relationships:

Have there been any abuse issues for the child? (neglect, emotional, physical, sexual) Yes No
Please explain briefly:

SECTION IV: PREGNANCY AND BIRTH HISTORY

1. How many weeks did pregnancy last (normal 38-42 weeks):_____

(If the child was premature, please completed Section XIV: Prematurity and Newborn Intensive Care Addendum)

2. Please list any medications taken during pregnancy (include vitamins, all prescription drugs and over the-counter drugs)

Medication	Months Take (of 9)	Dose	Reasons for taking Medication

3. Was alcohol consumed during pregnancy? Yes No

4. Was there smoking or tobacco used during pregnancy Yes No

5. Were any other drugs (not prescribed) used during pregnancy? Yes No
   If yes, please describe the drug(s) and how often:

6. Were there any illnesses during pregnancy? Yes No

7. Were there any traumas during pregnancy? Yes No
   If yes, please describe:

8. Was an amniocentesis done during pregnancy? Yes No
   If yes, please describe results:

9. Was there any exposure to chemical, toxic substances, or people with infections during the pregnancy? If yes, describe: Yes No

10. Were there any difficulties in the child during or immediately after birth? Yes No
    If yes, please complete Section XV: Prematurity and Newborn Intensive Care Addendum

11. Was your child's hearing screened at birth? Yes No
    Results: Pass Referred

12. Did your child nurse or was he/she bottle fed?
    Were there any difficulties with: latching on coordinating suck/breathe swallow
    loud/sloppy eating tiring easily/early

Child's birth weight _____ pounds _____ ounces
APGAR scores at 1 minute _____ 5 minutes _____

SECTION V: DEVELOPMENTAL PROGRESSION

At what point did you become concerned about your child's development and/or behavior, and why?

_____

_____

_____

_____

Developmental Milestones: (Note **age in months** for each milestone achieved. Estimate if unsure).

Milestone	Months	Typical	Milestone	Months	Typical
Smile		2-4	Removes Clothes on own		13-19
Roll Over		2-5	Climbs Stairs		14-20
Grasp Rattle		3-4	Combine 2 Words		14-24
Reach For Object		3-5	Stack 4 or more blocks		15-20
Turns To Voice		3-5	Uses Plurals		21-36
Babbled		5-8	Pedals Tricycle		21-28
Hand To Hand Transfer		4-7	Ability To Draw Simple Figures		28-36
Sit Independently		6-9	Understands Simple Command or Question		18-30
Self-Feed Finger Foods		6-8	Dress Self		30-42
Crawl		6-10	Balance on One Foot		30-44
Pincer Grasp		8-12	First Sentence (3 + Words)		24-36
Stranger Anxiety		8-15	Draw Square		60
First Word (Speech Or Sign)		9-13	Ride Bike Without Training Wheels (not a strider)		4-6 years
Stand		10-13	Bladder Trained (Day)		2-3 years
Walk		10-13	Bladder Trained (Night)		2-4 years
Drink From Regular Cup		10-14	Bowel Trained		2-4 years

Please describe any difficulties with any of the above milestones:

_____

_____

_____

_____

Was any of the following present **to an unusual degree** during :

I = Infancy (0-18 months); T = Toddler (18 months-3 years); or P = Preschool (3-5 years)

General

____ Re-occurring ear infections/tubes placed
____ Poisonings/toxic exposure
____ Colic/reflux
____ Poor weight gain
____ Difficulty sucking/chewing/swallowing
____Difficult to wean/self-weaned early
____ Lethargy
____ Restless
____ Disrupted sleep
____Nightmares/Night Terrors
____Difficult to calm/pacify
____ Irritability/easily agitated
____ Aggression
____ Clumsy/uncoordinated
____ Accident prone
____ Highly active
____ Loss of abilities/regression

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196

Sensory and motor Development

___Problems with hyper or hyposensitivity
___ Staring or avoiding looking at things
___ Odd or repetitive movements with body (e.g. toe walk, hand flap, rocking, spinning, or head banging etc.)
___ Masturbation
___ Thumb sucking/Teeth grinding/chewing on things
___ Did not like to be held or comforted
___Smelling, banging, licking objects
___Picky or restricted eating

Play and social development

___ Isolated/Disinterested in others/"in own world"
___ Unusual play behaviors
___ Difficulty interacting/playing with others
___ Interest in toy parts, such as car wheels
___ Obsessed with certain things or topics
___Fascination with spinning objects or self

Language Development:

___ Making or maintaining eye contact
___ Loss of acquired speech
___ Unusual noises or infantile squeals
___ Voice louder/softer than required, or odd tone
___ Responding to name when called
___ Frequent gibberish or jargon
___ Understanding basic directions
___ Pulls others around when wants something
___ Expressing needs or desires, or using gestures
___ Initiation of speech and communication
___ Quotes movies or TV shows
___ Repetitive use of words or phrases
___ Having a conversation
___ Odd use of language (wrong words, phrases)
___Early/precocious reading/number skills

Is your child: _____ Right-handed _____ Left-handed _____Ambidextrous _____Not yet sure
Age handedness became obvious? _____
Family history of left handedness? Yes No
Has your child ever changed handedness Yes No

Physical developmental progressing without complications? Yes No
Age at first pubertal development _____
Sex education provided at home, school, church? Yes No
Is your child dating? Yes No
Is or has your child been sexually active? Yes No
Taking or using birth control? Yes No

Are the child's personal hygiene skills appropriate? Please explain
_____
_____
What are your child's chores/responsibilities at home, and how well are they performed? Please explain
_____
_____
Is or has your child been employed or had small jobs? Yes No
_____
_____

Does your teenager/young adult hold a learner's permit or driver's license? Yes ☐ No ☐
Any concerns with driving or navigation skills? Yes ☐ No ☐
(describe problems)_____

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196

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
___ Concerns for gender identity
___ 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
___ Has certain rituals/routines
___ Sees, feels, hears or smells things that are not there
___ Sad, withdrawn or lonely
___ 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 use
___ Alcohol use
___ 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

Which specific behaviors interfere with development or family functioning?_____

_____
_____
_____

Types of discipline you use or have used with your child: _____

_____
_____

Is discipline effective? Yes No

Explain: _____

_____
_____

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196

Have you taken any classes on parenting skills? Yes No

Check the courses taken/books read:

___ Parenting with Love and Logic
___ 1-2-3 Magic
___ SOS Help for Parents
___ Parent Effectiveness Training
___ Other _____

SECTION VII: SOCIAL HISTORY

Does your child seek out friends? Always 1 2 3 4 5 Never
Do other children seek out your child to socialize? Always 1 2 3 4 5 Never
Does your child relate well to other children? Always 1 2 3 4 5 Never
Does your child understand the rules of social interaction? Always 1 2 3 4 5 Never

Are your child's friends: older _____ younger _____ same age _____

Please explain problems with friendships or peers: _____

_____

_____

_____

_____

Who is child's best friend? _____

Any difficulties with:

___ Domineering
___ Withdrawn
___ Disinterested in others
___ Group play
___Imagination/Creativity
___ Initiating play
___ Making new friends
___ Keeping old friends
___ Independent play
___ Imitating play activities
___ Compromising
___ Sharing or taking turns
___ Being accepted
___Tolerating not doing well or losing
___Repetitive play

What are the best things about your child? _____

_____

_____

_____

What are your child's areas of great accomplishment? _____

_____

_____

What does your child enjoy doing most? _____

_____

_____

What does your child dislike doing? _____

_____

_____

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196

Does your child participate in sport activities? Describe

_____

_____

Does your child participate in music or art activities/lessons? Describe

_____

_____

SECTION VII: SCHOOL EXPERINCE /LEARNING PROBLEMS

Did/does your child receive Early Intervention? Yes No

If so, please bring copy of IFSP.

Schools Attended	Grades:	Academic concerns	Behavioral concerns
Preschool			
Kindergarten			
Elementary			
Middle/Junior High			
High School			
Post High School			

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

Reading _____Spelling _____ Arithmetic _____ Writing _____

Has your child ever been held back or has retention ever been suggested? Yes No

If yes, please explain: _____

_____

_____

Has your child ever been in Title One Resource or Special Education placement? Yes No

If yes, when and for what services? _____

_____

_____

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196

If applicable, please circle your child's classification(s) through Special Education:

Autistic Disorder	Behavioral Disordered	Communication Disordered
Developmental Delay	Hearing Impaired	Intellectually Handicapped
Specific Learning Disability	Multiply Handicapped	Other Health Impaired
Traumatic Brain Injury	Visually Handicapped	

When was the last IEP or 504 Plan, and what were the goals? (**Attach if possible**)

_____

_____

Does your child receive any of the following in school: (please circle)

Adapted physical education	Physical therapy
Occupational therapy	Speech therapy
Counseling	Tutoring

Does (or has) your child received private tutoring? Yes No

Explain: _____

_____

Has your child received psychological or educational testing by the school? Yes No

***Please provide copies of all previous test results/reports.**

Describe the process of doing homework each night with your child:

_____

_____

_____

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

___ Attention/concentration	___ Poor memory	___ Anxious or sad
___ Distractibility	___ Following directions	___ Math problems
___ Hyperactivity	___ Not turning in assignments	___ Handwriting
___ Behavior problems	___ Doesn't get along well	___ Reading/spelling problems
___ Aggression	___ Withdrawal	___ Other _____
___ Oppositional	___Few friends	

Does your child participate in extra-curricular activities at school (e.g. sports, clubs)? If so, what are they? _____

_____

SECTION VIII: PRESENT MEDICAL STATUS

Any allergy problems we should be aware of? _____

(if food allergies, please let us know and bring your own snacks for the child)

Current medical problems for which your child is being treated:

_____

_____

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196

Surgeries: _____

Has/Did your child had/have frequent ear infections Yes No

Did he/she have pressure equalization tubes placed? Yes No
Age(s) at time of surgery _____

Has your child received an audiological evaluation? Yes No
Date _____ Results _____

Does your child use hearing aids? Yes No
Ear(s) fit: Right Left Both Age aids were fit? _____
Type of hearing aids _____
Does your child benefit from wearing hearing aids? Yes No
Does your child wear hearing aids consistently? Yes No

Does your child have a cochlear implant? Yes No
If yes, which ear(s): Right Left Both Date of Surgery? _____
CI Model/Make: _____

Has your child received an ophthalmologic evaluation or
vision screening? Yes No

When was his/her last ophthalmologic evaluation? _____

Does your child use or require any special equipment? Yes No
(Please be sure to bring necessary equipment to evaluation)

____ crutches ____ wheelchair
____ walker ____ arm/hand splints
____ leg braces ____ hearing aid/cochlear implant
____ glasses ____ transmitter
____ cane ____ Communication Device (e.g. Proloquo) ___other _____

Does your child have any difficulties with sleep? Yes No
Sleep Schedule: In bed _____ Falls asleep_____Awakens in morning _____
If so does child:

Struggle to initiate sleep	Struggle to stay asleep	Awaken early
Move excessively in sleep	Snore	Talk in sleep
Sleepwalk	Night Terrors (how often?)	Nightmares (how often?)

Explain_____
_____

Is there a family history of sleep disorders? Yes No

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196

SECTION IX: MENTAL HEALTH HISTORY

Has your child received outpatient psychotherapy/counseling? Yes No

Therapist(s): _____
_____

Diagnosis: _____
_____

Duration of treatment: _____

Response to treatment/outcome: _____
_____
_____

Private psychological or developmental testing completed? When and by whom?
_____
_____
_____

*Please attach any test results available.

Has your child ever received acute psychiatric care? Yes No

Program _____ Dates of attendance: _____

Has your child ever attended Residential or Day Treatment Programs? Yes No
Program _____ Dates of attendance: _____
Program _____ Dates of attendance: _____

Have you used in-home services? Yes No

Early Intervention Family Preservation Respite In-home Mental Health

List any other agencies/individual providing regular services not mentioned elsewhere:
Name: _____
Address: _____
Phone: _____
Service: _____

Name: _____
Address: _____
Phone: _____
Service: _____

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196

SECTION X: MEDICATION HISTORY

On the average, how often does your child receive his/her medication in the correct dosage?

a. < 50% of the time
b. 50-80% of the time
c. 81-100% of the time

Is the child responsible for taking any doses of medication? Yes No

Are medications supervised? Yes No

Is the school responsible for giving any doses of medication? Yes No

Please list <u>all</u> past and present medications prescribed and the dosages or attach a list. Typically the child should be administered all regularly prescribed medications for testing. Please discuss with examiner if you have concerns or questions:

Medication	Prescribed by	Dosage	Date Started/Ended	Response/Side effects

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196

SECTION XI: NEUROLOGICAL HISTORY

Please check all that apply to your child:

___ Birth Injury
___ Developmental disorder
___ Seizures
___ Meningitis
___ Encephalitis
___ Traumatic brain injury
___ Genetic disorder
___ Metabolic disorder
___ Endocrine problems
___ Spinal cord injury
___ Brain tumor
___ Tuberous Sclerosis
___ Cerebral palsy
___ Skull fracture/concussion
___ Headaches * see question below
___ Hydrocephalus
___ Encephalopathy
___ Other _____

Age at initial diagnosis _____

Has your child ever had a seizure(s)? Yes No
If yes, please complete seizure addendum, section XIV

Has your child experienced any head injury or concussion? Yes No
If yes, please complete Accident/Injury Addendum, section XV

Did your child have neurologic problems surrounding birth? Yes No
If yes, please complete Prematurity/Neonatal Intensive Care, section XV

History of neurosurgery? Yes No

Condition/event Dates of surgeries

_____ _____
_____ _____

Does your child experience headaches? Yes No

Frequency? ____ times per (please circle) day week month year

Severity: mild 1 2 3 4 5 6 7 8 9 10 severe

Does your child have a warning if headaches are about to happen? Yes No

What interventions have been or are used for headaches?

Medications Craniosacral therapy Hypnosis None
Massage Relaxation Chiropractor
Distraction Physical therapy Biofeedback

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196

SECTION XII: OTHER PROFESSIONALS CONSULTED

List names and specialties of other professionals previously consulted:

Name Specialty

1. _____
2. _____
3. _____
4. _____

SECTION XIII: OTHER RESOURCES

DSPD Services? Yes No

Caseworker _____ Phone number _____

Has your child ever received physical therapy? Yes No

With whom: _____

Date: _____

Location: _____

Reason for evaluation: _____

Has your child ever received occupational therapy? Yes No

With whom: _____

Date: _____

Location: _____

Reason for evaluation: _____

Has your child ever received speech therapy? Yes No

With whom: _____

Date: _____

Location: _____

Reason for evaluation: _____

Has your child ever been tested by an audiologist? Yes No

With whom: _____

Date: _____

Location: _____

Reason for evaluation: _____

Results: _____

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196

SECTION XIV: NEUROLOGICAL HISTORY: SEIZURE ADDENDUM

Complete this section if your child has a history of seizure activity

Describe the seizures/events your child had or is currently having.

A. Type

____ convulsive generalized

B. Subtype

____ tonic-clonic
____ tonic (stiffening)
____ clonic (jerking)

____ non-convulsive generalized

____ myoclonic
____ absences (stares)
____ atonic (drop or loss of tone)
____ infantile spasms

____ unclassified
____ status epilepticus
____ partial **(if type is "partial" then complete C and D. If not, continue on the next section)**
____ complex
____ secondary generalized

C. Side: ____ left ____ right ____ generalized
____ bilateral ____ unknown

D. Region: ____ frontal ____ occipital ____ parietal
____ temporal ____ unknown

1. Age seizures began: _____
2. Description: _____
_____
_____
3. Have seizures changed from when they started? Yes No
If yes, please explain: _____
_____
4. How often do they occur?
____ daily ____ number per day
____ weekly ____ number per week (doesn't occur daily)
____ monthly ____ number per month (doesn't occur weekly)
5. Are there any things that seem to cause this seizure type to occur more often?
____ tired ____ lots of excitement
____ flickering lights ____ reading
____ illness ____ stress
____ upset ____ watching TV or computer games
____ other: _____

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196

6. How does he/she behave after seizures? Please mark all that apply:

____ resume activity ____ confused for awhile
____ sleep ____ become irritable
____ other: _____

ETIOLOGY:

Onset duet to (please also indicate age): ____unknown ____ encephalopathy
____ head injury ____ brain mass/tumor
____ malformation ____ infectious
____ other (please describe)_____

Has the child been diagnosed with:

____ Sturge Weber
____ Landau Kleffner Syndrome
____ Cortical Dysplasia
____ Schizencephaly
____ Hydrocephalus
____ Lennox-Gastaut Syndrome
____ Tuberous Sclerosis
____ Partial/Agenesis of Corpus Callosum
____ Encephalopathy
____ Other _____

Previous epilepsy surgical evaluation? Yes No

General Questions:

Have the seizures changed the way the child acts in any way? Yes No

Have grades in school gone down? Yes No

Does the child play or socialize less with friends? Yes No

Does the family understand the problems related to the seizures? Yes No

Have the seizures limited what the child wanted to do in any way ? Yes No

What effect have the seizures had on the family life?

____ financial ____ acting out with other children
____ emotional ____ decrease in number of social activities
____ divorce or separation ____ discipline problems with siblings
____other _____

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196

SECTION XV: PREMATURITY AND NEWBORN INTENSIVE CARE ADDENDUM

Complete this section if your child had complications surrounding birth

Newborn Intensive Care

Where: _____

Dates _____

DIAGNOSES: Please check all that apply

____ Bronchopulmonary Dysplasia
____ Pneumonia type: _____
____ Retinopathy of prematurity grade: _____
____ Intraventricular Hemorrhage right grade: _____ left grade: _____
____ Apnea and Bradycardia
____ Jaundice highest bilirubin level: _____
____ PDA (patent ductus arteriosus)
____ Congenital heart problems describe: _____
____ Infections describe: _____

Did your child receive:

____ Intubation
____ Oxygen
____ Surfactant
____ Antibiotics types: _____
____ Chest tube when: _____
____ Umbilical catheters when: _____
____ Surgeries detail: _____
when: _____
____Incubator when: _____
detail: _____

POST NEWBORN INTENSIVE CARE UNIT HISTORY

How old was the baby when he/she went home? _____

Monitored? Yes No
Home oxygen? Yes No
Age discontinued: _____

Neonatal follow up? Yes No
Dates of service: _____

Other history: _____
_____
_____
_____

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196

SECTION XVI: ADDENDUM: ACCIDENT/INJURY

Complete this section if your child experienced accidents or illnesses that may have affected the brain or central nervous system

Date of accident/injury: _____
Details:

_____
_____
_____

Was the child taken to the emergency/urgent care? Yes No
What is the name of the medical facility? _____

What were the results of the medical evaluation? _____
_____
_____

Immediately following the injury/illness, circle any behaviors which applied:

Agitated/Irritable Confused Combative (fighting) Unresponsive

Did your child experience a loss of consciousness? Yes No
If yes, how long? _____

Was your child comatose? Yes No
Duration of coma: _____

Glasgow coma scale (GCS) rating at scene? 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

Glasgow coma rating (GCS) at ER admission? 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

Did child receive:
____ Intensive Care Duration of ICU care _____
____ Intubation Duration of intubation _____
____ Extra ventricular drain/pressure bolt Duration of drain/bolt _____

Did child receive rehabilitation services following the injury/illness?

Physical Therapy Speech Therapy Occupational Therapy

Diagnostic studies completed, check all that apply:
____ x-rays Specify: _____ by: _____
____ CT scan Specify: _____ by: _____
____ MRI Specify: _____ by: _____

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196

___ EEG Specify: _____ by: _____
___ SPECT Specify: _____ by: _____
___ Angiogram Specify: _____ by: _____

Does your child experience post-injury headaches? Yes No
Frequency of headaches: _____

Severity mild 1 2 3 4 5 6 7 8 9 10 severe

Have sleep patterns changed? Yes No
If yes, please describe: _____
_____
_____

Which, if any, of the symptoms below has your child experienced since being injured?
If symptoms were present before the injury, but changed after, please explain below.

___ Nausea
___ Vomiting
___ Ringing in ears
___ Blurred vision
___ Aggression
___ Sexually acting out
___ Fainting/blackouts
___ Memory problems
___Depression
___Pain
___ Anxiety
___ Decreased attention
___ Easily fatigued
___ Decreased energy
___ Weight gain/loss
___ Difficulty with crowds
___ Difficulty with noise/light
___Mood swings
___Hallucinations
___Easily overwhelmed
___Socially awkward
___ Nightmares, Night terrors

Changes in:
___ Speech/language
___ Reading
___ Math skills
___ Sense of smell
___ Sense of taste
___ Vision
___Anger
___ Stress tolerance
___ Frustration threshold
___ Motor skills

Please provide any additional information that you feel may be of benefit in understanding the consequences of the injury?

_____
_____
_____
_____
_____
_____
_____
_____

Wasatch Pediatric Neuropsychology
231 East 400 South, Suite 335
Salt Lake City, UT 84111
p. (801) 363-1189
f. (801) 363-1196