



WASATCH PEDIATRIC
NEUROPSYCHOLOGY

PEDIATRIC NEURODEVELOPMENTAL HISTORY FORM

Child's Name

Date Completed

Person Completing Form

Wasatch Pediatric Neuropsychology, Inc.
www.kidsneuropsych.com

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Pediatric Neuropsychologists

Child's Full Legal Name _____

Gender _____ Birth Date _____ Current Age _____ Current Grade _____

School _____ District _____

Child presently lives with:

_____ Biological Parents _____ Mother _____ Father/Step Mother
_____ Adoptive Parents _____ Father _____ Mother/Step Father
_____ 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



SECTION I. FAMILY AND SOCIAL HISTORY

Marital status of primary caregiver(s):

_____ Single _____ Separated How long? _____
_____ Married How long? _____ _____ Divorced How long? _____
_____ Cohabiting 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:

Name	Age	Medical, social or school problems?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What languages are spoken in the home? _____



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



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

Please check all that apply to your adopted child:

- | | |
|---|---|
| <input type="checkbox"/> Difficulty with bonding | <input type="checkbox"/> Better behaved outside the home |
| <input type="checkbox"/> Difficulty with eye contact | <input type="checkbox"/> Excessive reaction to minor events |
| <input type="checkbox"/> Social Withdrawal | <input type="checkbox"/> Indifferent to family members |
| <input type="checkbox"/> Over-friendly with strangers | |

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 in the family? (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).

<u>Milestone</u>	<u>Months</u>	<u>Normal</u>	<u>Milestone</u>	<u>Months</u>	<u>Normal</u>
Smile		2-4	Removes Clothes		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
Crawl		4-6	Uses Plurals		21-36
Turns To Voice		4-8	Pedals Tricycle		21-28
Hand To Hand Transfer		4-7	Ability To Draw Simple Figures		28-36
Sit Independently		5-8	Understands Simple Command or Question		18-30
Self-Feed Finger Foods		5-8	Dress Self		30-42
Babbled		5-8	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 (<u>not</u> 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:

Were 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)

- 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
- Difficult to calm/pacify

Explanations:



- Irritability/easily agitated
- Did not like to be held or comforted
- Aggression
- Thumb sucking/Teeth grinding/chewing on things
- Nightmares/Night Terrors
- Clumsy/uncoordinated
- Accident prone
- Masturbation
- Highly active
- Problems with hyper or hyposensitivity
- Difficulty making or maintaining eye contact
- Difficulty responding to name when called
- Staring or avoiding looking at things
- Odd or repetitive movements with body (e.g. toe walk, hand flap, rocking, spinning, or head banging etc.)
- Isolated/Disinterested in others/"in own world"
- Unusual play behaviors
- Difficulty interacting/playing with others
- Loss of abilities/regression
- Other _____

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

Issues with sexually inappropriate behavior? _____

Yes No

Taking or using birth control? _____

Yes No

History of drug or alcohol experimentation or use? _____

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 driver's permit or license? Yes No

Any concerns with driving skills? _____

Yes No

(describe problems) _____



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

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

Is your child experiencing any of the following problems?

- | | | |
|--|--|--|
| <input type="checkbox"/> Drugs/substance abuse | <input type="checkbox"/> Violent behavior | <input type="checkbox"/> History of sexual abuse (victim) |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Lying/Cheating | <input type="checkbox"/> History of sexual abuse (perpetrator) |
| <input type="checkbox"/> Cruelty to animals | <input type="checkbox"/> Suicidal threats/gestures | <input type="checkbox"/> Inappropriate sexual behavior |
| <input type="checkbox"/> Actively rebelling | <input type="checkbox"/> Legal issues/arrest/detention | <input type="checkbox"/> Pornography |
| <input type="checkbox"/> Vandalism/stealing | | |

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: _____



Have you taken any Classes on parenting skills? Yes No

Check the courses taken/books read:

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

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
- Initiating play
- Compromising
- Withdrawn
- Making new friends
- Sharing or taking turns
- Disinterested in others
- Keeping old friends
- Being accepted
- Group play
- Independent play
- Tolerating not doing well or losing
- Imagination/Creativity
- Imitating play activities
- 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? _____



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?



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

Autistic Disorder
Developmental Delay
Specific Learning Disability
Traumatic Brain Injury

Behavioral Disordered
Hearing Impaired
Multiply Handicapped
Visually Handicapped

Communication Disordered
Intellectually Handicapped
Other Health Impaired

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
Occupational therapy
Counseling

Physical therapy
Speech therapy
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
___ Distractibility
___ Hyperactivity
___ Behavior problems
___ Aggression
___ Oppositional

___ Poor memory
___ Following directions
___ Not turning in assignments
___ Doesn't get along well
___ Withdrawal
___ Few friends

___ Anxious or sad
___ Math problems
___ Handwriting
___ Reading/spelling problems
___ Other _____

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:



Surgeries: _____

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

Did he/she have pressure equalization tubes placed? Yes No
Age 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 your 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 he/she:
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

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: _____



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 all 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

SECTION XI: NEUROLOGICAL HISTORY

Please check all that apply to your child:

- | | |
|---|---|
| <input type="checkbox"/> Birth Injury | <input type="checkbox"/> Spinal cord injury |
| <input type="checkbox"/> Developmental disorder | <input type="checkbox"/> Brain tumor |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Tuberos Sclerosis |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Cerebral palsy |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Skull fracture/concussion |
| <input type="checkbox"/> Traumatic brain injury | <input type="checkbox"/> Headaches * see question below |
| <input type="checkbox"/> Genetic disorder | <input type="checkbox"/> Hydrocephalus |
| <input type="checkbox"/> Metabolic disorder | <input type="checkbox"/> Encephalopathy |
| <input type="checkbox"/> Endocrine problems | <input type="checkbox"/> 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 | |



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: _____



SECTION XIV: NEUROLOGICAL HISTORY: SEIZURE ADDENDUM

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

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

- A. Type
 convulsive generalized

 non-convulsive generalized

 unclassified
 status epilepticus
 partial (if type is "partial" then complete C and D. If not, continue on the next section)
 complex
 secondary generalized
- B. Subtype
 tonic-clonic
 tonic (stiffening)
 clonic (jerking)

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

- 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: _____



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

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

ETIOLOGY:

Onset due 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 Tuberos Sclerosis
- Landau Kleffner Syndrome Partial/Agenesis of Corpus Callosum
- Cortical Dysplasia Encephalopathy
- Schizencephaly Other _____
- Hydrocephalus
- Lennox-Gastaut Syndrome

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 _____

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: _____
- 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: _____

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: _____



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.

- | | |
|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Decreased attention |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Easily fatigued |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Decreased energy |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Weight gain/loss |
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Difficulty with crowds |
| <input type="checkbox"/> Sexually acting out | <input type="checkbox"/> Difficulty with noise/light |
| <input type="checkbox"/> Fainting/blackouts | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Easily overwhelmed |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Socially awkward |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Nightmares, Night terrors |

- Changes in:
- | | |
|--|--|
| <input type="checkbox"/> Speech/language | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Math skills | <input type="checkbox"/> Stress tolerance |
| <input type="checkbox"/> Sense of smell | <input type="checkbox"/> Frustration threshold |
| <input type="checkbox"/> Sense of taste | <input type="checkbox"/> Motor skills |

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

