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

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Child's Full Legal Name ____

Gender __________ 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**

SECTION I. FAMILY AND SOCIAL HISTORY

Marital status of primary caregiver(s):

______ Single
______ Married How long? _________
______ Cohabitating How long? _________
______ Separated How long? _________________
______ Divorced 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? ____

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
____
____

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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/atttachment
____ 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	Normal	Milestone	Months	Normal
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:

____
____
____
____

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
____ Difficulty with feeding and/or food preferences
____Difficult to wean/self-weaned early
____ Lethargy
____ Restless
____ Disrupted sleep

Explanations:

____Difficult to calm/pacify
____ 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
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 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:

____ 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: ____
____
____

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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? ____

____

____

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:
____
____
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 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____
____

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____
____
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:

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

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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	B. Subtype
____ convulsive generalized	____ 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: ______________________________

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 ____

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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: ______________________________
____
____
____

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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.

____ 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?
____
____
____
____
____
____
____
____

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