PEDIATRIC NEURODEVELOPMENTAL HISTORY FORM

______________________________  Child’s Name

_______________________________  Date Completed

______________________________  Person Completing Form

Wasatch Pediatric Neuropsychology, Inc
Julien Smith, Ph.D.
Julia Jacobs, Psy.D.
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     _____ Other

_____ Adoptive Parents      _____ Father     _____ Mother/Step Father

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?

_________________________________________________________________

_________________________________________________________________

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

(If you do not provide address information, the report will not be sent)

Name          Address          Phone

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

○ Please sign release of information in office 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 Date of divorce _______________
- Cohabitating

**Biological Mother:** _____________________________________________ Age: __________

**Education:**
- Highest grade completed ____________ (1-12) High school graduate/GED (circle one)
- Number of college credit hours completed ________________________________
- 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)
- Number of college credit hours completed ________________________________
- 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)
- Number of college credit hours completed ________________________________
- 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)
- Number of college credit hours completed ________________________________
- Highest degree awarded ________________________________
- Vocational Training ________________________________ Years ____________
- Current employment ________________________________ Hours/wk ________

*If your child was adopted, please complete Section II.*

Additional children in the family:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Medical, social or school problems?</th>
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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**, is there any history of the following? M = Mother, F = Father, S = Sister, B = Brother, GM = Grandmother, GF = Grandfather, U = Uncle, A = Aunt, C = Cousin

<table>
<thead>
<tr>
<th>Mother’s side of family</th>
<th>Father’s side of family</th>
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<tbody>
<tr>
<td>___ Learning problems</td>
<td>___ Learning problems</td>
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<tr>
<td>___ School problems</td>
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<tr>
<td>___ Attention/concentration problems</td>
<td>___ Attention/concentration problems</td>
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<tr>
<td>___ Hyperactivity</td>
<td>___ Hyperactivity</td>
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<tr>
<td>___ Anxiety</td>
<td>___ Anxiety</td>
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<tr>
<td>___ Obsessive-Compulsive Disorder</td>
<td>___ Obsessive-Compulsive Disorder</td>
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<tr>
<td>___ Depression</td>
<td>___ Depression</td>
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<tr>
<td>___ Alcoholism/Drug Abuse</td>
<td>___ Alcoholism/Drug Abuse</td>
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<tr>
<td>___ Developmental Disability</td>
<td>___ Developmental Disability</td>
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<tr>
<td>___ Intellectual Disability</td>
<td>___ Intellectual Disability</td>
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<tr>
<td>___ Autism/Pervasive Developmental Disorder</td>
<td>___ Autism/Pervasive Developmental Disorder</td>
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<tr>
<td>___ Bipolar Disorder</td>
<td>___ Bipolar Disorder</td>
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<td>___ Seizure Disorder</td>
<td>___ Seizure Disorder</td>
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<tr>
<td>___ Genetic Disorder</td>
<td>___ Genetic Disorder</td>
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<tr>
<td>___ Head Injury</td>
<td>___ Head Injury</td>
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<tr>
<td>___ Metabolic Disease</td>
<td>___ Metabolic Disease</td>
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<tr>
<td>___ Other neurologic condition</td>
<td>___ Other neurologic condition</td>
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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  Number of placements __________________

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:

___ Difficulty with bonding  ___ Better behaved outside the home

___ Difficulty with eye contact  ___ Excessive reaction to minor events

___ Social Withdrawal  ___ Indifferent to family members

___ 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)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Months Take (of 9)</th>
<th>Dose</th>
<th>Reasons for taking Medication</th>
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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? Yes No
   If yes, describe:

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. Did your child nurse? Yes No
    If yes, were there any difficulties with: latching on coordinating suck/breathe swallow

Child’s birth weight ______________ pounds ________________ ounces
Child’s birth length _______________ inches

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: (List age and months for each milestone achieved. Approximate if unsure).

___ Rolled over  ___ Babbled  ___ Ability to hold crayon or pencil to color
___ Sat Alone  ___ First word (speech or sign)  ___ Ability to draw simple figures
___ Crawled  ___ First Sentences  ___ Bladder trained (night)
___ Walked  ___ Understood “no”  ___ Bladder trained (day)
___ Peddled a tricycle  ___ Rode bike without training wheels  ___ Bowel trained

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)

___ High fevers  Explanations:  
___ Excessive pain/ discomfort
___ 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
___ Irritability/easily agitated
___ Did not like to be held
___ Aggression
___ Thumb sucking
___ Nightmares
___ Clumsy/uncoordinated
___ Accident prone
___ Masturbation
___ Highly active
___ Difficulty making eye contact
___ Staring or avoiding looking at things
___ Rocking, spinning, or head banging
___ Walking on tiptoes, or flapping hands
___ Unusual play behaviors
___ Difficulty interacting/playing with others
___ Slow to roll, crawl or walk
___ Slow to use words or sentences
___ Loss of abilities/regression
___ Other ________________________

Is your child: _______ Right-handed       ______ Left-handed       ______ Ambidextrous

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
Is or has your child been employed or had small jobs? Yes No
Please explain ________________________________________

Check the behaviors that you believe your child currently exhibits to an exaggerated degree compared to siblings of other children of the same age:
___ High activity
___ Impulsivity (poor self control)
___ Interrupts frequently
___ Poor attention span
___ Acts as if “driven by a motor
___ Heedless to danger
___ Difficulty finishing tasks
___ Disorganized
___ Accident prone
___ Low frustration tolerance
___ Excessive swearing
___ Unusually aggressive
___ Temper outbursts
___ Clumsy/sloppy
___ Does not listen
___ Does not understand or learn from
   Consequences or experience
___ Does not respond to discipline
___ Socially awkward/odd
___ A “different” child
___ Tics/twitching
___ Other concerning behavior
___ Difficulty with sleep
___ Daytime accidents
___ Bedwetting
___ Worried or anxious
___ Gets lost easily
___ Poor memory
___ Does not think logically
___ Problems understanding jokes
___ Poor awareness of time
___ Problems expressing self
___ Talking around issues, can’t come to a point
___ Does or says things over and over
   (perseveration)
___ Problems changing activities
___ Sad, withdrawn or lonely
___ Sees, feels, hears things that are not there
___ Pulling out own hair
___ Self harm
___ Picky eater
___ Chewing/swallowing difficulties
___ Binging/Purging
___ Diet restriction

Is your child experiencing any of the following problems?
___ Drugs/substance abuse
___ Alcohol
___ Cruelty to animals
___ Actively rebelling
___ Violent behavior
___ Lying/cheating
___ Suicidal threats/gestures
___ Inappropriate sexual behavior
___ History of sexual abuse (victim)
___ History of sexual abuse (perpetrator)

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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: __________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

Who is child’s best friend? __________________________________________________________

Is your child different than his/her peers? Yes No

Please explain: ________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

Any difficulties with:

___ Bossy  ___ Initiating play  ___ Compromising

___ Withdrawn  ___ Making new friends  ___ Sharing

___ Disinterested  ___ Keeping old friends  ___ Being accepted

in others  ___ Group play  ___ Individual 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? Yes No
Describe _____________________________________________________________
____________________________________________________________________________________

Does your child participate in music or art activities/lessons? Yes No
Describe _____________________________________________________________
____________________________________________________________________________________

SECTION VII: SCHOOL EXPERIENCE/LEARNING PROBLEMS

Did/does your child receive Early Intervention? Yes No
If so, please bring copy of IFSP.

<table>
<thead>
<tr>
<th>Schools Attended</th>
<th>Grades</th>
<th>Academic concerns</th>
<th>Behavioral concerns</th>
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<tbody>
<tr>
<td>Preschool</td>
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<td>Kindergarten</td>
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<tr>
<td>Elementary</td>
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<tr>
<td>Middle/Junior High</td>
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<td>High School</td>
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<tr>
<td>Post High School</td>
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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
- Behavioral Disorder
- Communication Disorder
- Developmental Delay
- Hearing Impaired
- Intellectually Handicapped
- Learning Disabled
- 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
- 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

Height ____________________  Weight ____________________

Current medical problems for which your child is being treated:

Surgery:

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 ________________________

Does your child have any hearing problems?  Yes  No
Explain ________________________________

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

Has your child received an ophthalmologic evaluation or vision screening?  Yes  No
When was your last ophthalmologic evaluation? ________________________
With? ________________________

Does your child have any difficulties with sleep?  Yes  No
If so does he/she:
  Struggle to initiate sleep
  Struggle to stay asleep
  Move excessively in sleep
  Sleepwalk
  Awaken early
  Snore
  Night Terrors (how often?)
  Nightmares (how often?)
Explain _____________________________________________________________________________
____________________________________________________________________________________

Is there a family history of sleep disorders?  Yes  No

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  ____ other ______________________

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: ___________________________
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?  

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<th>Yes</th>
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Are medications supervised?  

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Is the school responsible for giving any doses of medication?  

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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:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Prescribed by</th>
<th>Dosage</th>
<th>Date Started/Ended</th>
<th>Response/Side effects</th>
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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 _________

Initial complaints or symptoms:

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

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?
  Please circle those used and underline those that are effective.

  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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Specialty</th>
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<tbody>
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<td>1. __________________________</td>
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<td>2. __________________________</td>
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<td>4. __________________________</td>
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Pediatrician/family physician: __________________________
Address/phone number: __________________________

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

B. Subtype
   ____ tonic-clonic
   ____ tonic (stiffening)
   ____ clonic (jerking)
   ____ myoclonic
   ____ absences (stares)
   ____ atonic (drop or loss of tone)
   ____ infantile spasms
   ____ 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
   ____ weekly
   ____ monthly
   ____ number per day
   ____ number per week (doesn’t occur daily)
   ____ number per month (doesn’t occur weekly)

5. Are there any things that seem to cause this seizure type to occur more often?
   ____ tired
   ____ flickering lights
   ____ illness
   ____ upset
   ____ reading
   ____ stress
   ____ watching TV or computer games
   ____ other: _______________________________________________________

6. How does he/she behave after seizures? Please mark all that apply:
   ____ resume activity
   ____ sleep
   ____ confused for awhile
   ____ 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
- Tuberous 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: ______ left grade: ______
___ Intraventricular Hemorrhage right 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: _____________________________

POST NEWBORN INTENSIVE CARE UNITY HISTORY

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

Monitored? Yes No
Summarize: ______________________________________________________

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 room? 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 or pressure bolt  Duration of drain/bolt ______________________________

Did child receive rehabilitation services following the injury/illness?

Physical Therapy  Speech Therapy  Occupational Therapy

If so, where and what were the results of the therapy? _____________________________________________

Diagnostic studies completed, check all that apply:

___ x-rays  Specify: ____________________________ by: ____________________________

___ CT scan  Specify: ____________________________ by: ____________________________

___ MRI  Specify: ____________________________ by: ____________________________

___ EEG  Specify: ____________________________ by: ____________________________
Does your child experience post-injury headaches?  Yes  No

Frequency of headaches: __________________________________________________________

<table>
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<th>Severity</th>
<th>mild</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>severe</th>
</tr>
</thead>
</table>

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 ___ Decreased attention
___ Vomiting  ___ Easily fatigued
___ Ringing in ears ___ Decreased energy
___ Blurred vision ___ Weight gain/loss
___ Aggression  ___ Difficulty with crowds
___ Sexually acting out ___ Difficulty with noise/light
___ Fainting/blackouts ___ Mood swings
___ Memory problems ___ Hallucinations
___ Depression  ___ Easily overwhelmed
___ Pain ___ Socially awkward
___ Anxiety ___ Nightmares, Night terrors

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

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

____________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________