NEURODEVELOPMENTAL HISTORY FORM

_____ _____
Child's Name

_____
Date of Evaluation

_____
Name of Person Completing Form

Child's full legal name_____

Gender_____Birth Date_____Current Age_____Current Grade_____

School_____District_____

Home address_____ Home phone ( )_____
Work phone ( )_____
_____ Cell phone ( )_____

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 professionals to whom you would like this report to be sent:
Name Address Phone
_____
_____
_____
_____

☐ Sign release of information

SECTION I. FAMILY AND SOCIAL HISTORY

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)
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)
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)
Number of college credit hours completed_____
Highest degree awarded_____
Vocational Training_____Years_____
Current employment_____Hours/wk_____

Additional children in the family:

Name	Age	Medical, social or school problems?

Is there any history of the following? Please respond in relation to your child: M = mother, F = Father, S = Sister, B = Brother, GM = Grandmother, GF = Grandfather, U = Uncle, A = Aunt, C = Cousin

Mother's side of family

_____ Learning problems
_____ School problems
_____ Attention/concentration problems
_____Hyperactivity
_____Anxiety
_____Obsessive-Compulsive Disorder
_____Depression
_____Alcoholism/Drug abuse

Father's side of family

_____Learning problems
_____ School problems
_____ Attention/concentration problems
_____ Hyperactivity
_____ Anxiety
_____Obsessive-Compulsive Disorder
_____Depression
_____Alcoholism/Drug abuse

Mother's side of family

_____Developmental Disability
_____Mental Handicap
_____Autism/Pervasive Developmental Disorder
_____Bipolar Disorder
_____Seizure Disorder
_____Genetic Disorder
_____Head Injury
_____Metabolic Disorder
_____Other neurological condition

Father's side of family

_____Developmental Disability
_____Mental Handicap
_____Autism/Pervasive Developmental Disorder
_____Bipolar Disorder
_____Seizure Disorder
_____Genetic Disorder
_____Head Injury
_____Metabolic Disorder
_____Other neurological condition

Have any of your child's other blood relatives experienced problems similar to those your child is currently experiencing? If so, please describe_____
_____
_____
_____

SECTION II: SOCIAL HISTORY

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

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

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

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

Do you and your partner/other caregiver agree on the parenting style for this child? Explain.

Describe any problems between patient and siblings:

Describe overall, general family relationships:

Have there been any abuse issues in the family? (emotional, physical, sexual) Yes No

Please explain briefly:

SECTION III: PREGNANCY AND BIRTH HISTORY

1. How many weeks did pregnancy last (normal 38-42 weeks):_____
(if the child was premature, please complete Section XII: Prematurity and Newborn Intensive Care Addendum)

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

Medication	Months Taken (of 9)	Dose	Reason 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
If Yes, please describe:

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 XII: Prematurity and Newborn Intensive Care Addendum

11. Did you have, or were you treated for post-partum depression? Yes No

Child's birth weight _____pounds _____ ounces
Child's birth length _____ inches

APGAR scores I minute_____ 5 minutes_____

SECTION IV: DEVELOPMENTAL PROGRESSION:

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

Developmental Milestones: List age in years and months for each milestone achieved. (Approximate if unsure.)

_____Rolled over
_____Sat Alone
_____Crawled
_____Walked
_____Peddled a Tricycle

_____First Word (speech or sign)
_____First Sentences
_____Understood "no"
_____ Ability to hold Crayon/Pencil to Color

_____Bladder trained (night)
_____Bowel trained
_____Bladder trained (day)

Were any of the following present to an unusual degree during Infancy (0 – 18 months), Toddler (18 months – 3 years) or Preschool (3 – 5 years). I = Infancy, T = Toddler, P = Preschool

Explanations:

_____High fevers
_____Excessive pain/discomfort
_____Reoccurring 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

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)
_____Low frustration tolerance
_____Interrupts frequently
_____Poor attention span
_____Acts as if is "driven by a motor"
_____Excessive swearing
_____Unusually aggressive
_____Temper outbursts
_____Heedless to danger
_____Difficulty finishing tasks
_____Disorganized
_____Accident prone
_____Tics/twitching
_____Eats things that are not food
_____Difficulty with sleep
_____Clumsy/sloppy
_____Daytime accidents
_____Bedwetting
_____Too sensitive to sound/sight/touch/taste
_____Gets lost easily
_____Other concerning behaviors_____
_____

_____Does not listen
_____Poor memory
_____Does not think logically
_____Problems understanding jokes
_____Socially awkward/odd
_____Socially withdrawn
_____A "different" child
_____Poor awareness of time
_____Problems expressing self
_____Does not understand or learn from consequences or experience
_____Problems changing activities
_____Does not respond to discipline
_____Talking around issues, can't come to a point
_____Worried or anxious
_____Sad, withdrawn or lonely
_____Sees, feels, hears things that are not there
_____Does or says things over and over (perservation)
_____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
_____Cutting/burning self
_____Vandalism/stealing
_____Violent behavior
_____Lying/cheating
_____Suicidal threats or gestures
_____History of sexual abuse (victim)
_____History of sexual abuse (perpetrator)
_____Sexual activity

Any specific behaviors that 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 taking any classes on parenting skills? Yes No

Check the courses taken/books read:

_____Parenting with Love and Logic
_____1-2-3-Magic
_____SOS Help for Parents
_____Parent Effectiveness Training
_____Other_____

Physical development progressing without complications Yes No

**Please disregard this set of questions regarding physical development if your child has not reached puberty

Age of first pubertal development_____ Date of first menstrual period_____
Complications, if any_____

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? Yes No
Please explain

SECTION V: SOCIAL DEVELOPMENT

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 friends: older_____ younger_____ same age_____

Please explain problems with friendships:_____
_____
_____

Who is your child's best friend?_____

Different than peers? Yes No
Please explain:_____
_____
_____

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 sports activities? Yes No
Describe_____
_____

SECTION Vi: SCHOOL EXPERIENCE/LEARNING PROBLEMS

Did/does your child receive Early Intervention? Yes No

Did/does your child participate in a preschool program? Yes No
Describe_____
_____
_____

Briefly describe any behavior problems that affect your child's school experience:_____
_____
_____
_____

Briefly describe your child's overall academic performance:_____
_____
_____
_____

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

If present, at what point did academic problems become obvious?_____
_____
_____

Has your child ever been held back or has retention ever been suggested? Yes No
If yes, when? 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	Behavior Disordered	Communication Disordered
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.

How much time is spent each night doing homework with your child?_____
_____

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

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

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

SECTION VII: PRESENT MEDICAL STATUS

Height_____Weight_____

Current medical problems for which your child is being treated:_____
_____
_____

Surgeries?_____
_____

Hospitalization(s)?_____
_____

Specific current health problems or areas of concern?_____

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_____

Does your child have central auditory processing problems? Yes No

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

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

_____crutches
_____walker
_____leg braces
_____glasses
_____cane
_____wheelchair
_____arm/hand splints
_____hearing aid/cochlear implant transmitter
_____other_____

SECTION VIII: 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 medications? Yes No

Are medications supervised? Yes No

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

Do you feel that the medications address the problems they are prescribed to address? Yes No

Please list all past and present medications prescribed and the dosage:

Medication	Dosage	Date Started/Ended	Reason for Use	Side Effects Experienced/Reason for Discontinuation

SECTION IX: NEUROLOGICAL HISTORY

Please check all that apply to your child:

_____Birth injury
_____Developmental disorder
_____Seizures
_____Meningitis
_____Encephalitis
_____Spinal cord injury
_____Brain tumor
_____Tuberous Sclerosis
_____Cerebral palsy
_____Skull fracture/concussion
_____Traumatic brain injury
_____Genetic disorder
_____Metabolic disorder
_____Endocrine problems
_____Headaches* see questions below
_____Hydrocephalus
_____Encephalopathy
_____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 XI

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

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

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

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

Neurologist/neurosurgeons currently or previously following your child:
_____
_____
_____

SECTION X: OTHER PROFESSIONALS CONSULTED

List names and specialties of other professionals previously consulted:

Name	Specialty
1._____	
2._____	
3._____	
4._____	

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

Private psychological or developmental testing completed? When and by whom?_____
_____
Please attach any test results available.

SECTION XI: OTHER RESOURCES

Respite Care?:_____ Who provides?_____

DSPD Services?: Yes No
Case Worker_____ 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:_____
Results:_____

Has your child ever been tested by an audiologist? Yes No
With whom:_____
Date:_____
Location:_____
Reason for evaluation:_____
Results:_____

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 behavioral services? Yes No
List any other agencies/individual providing regular services not mentioned elsewhere:

Name	Address	Phone	Service
Name	Address	Phone	Service

SECTION XII: 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
- B. Subtype
  - _____tonic-clonic
    - _____tonic (stiffening)
    - _____clonic (jerking)
  - _____myoclonic
  - _____absences (stares)
  - _____atonic (drop or loss of tone)
  - _____infantile spasms

_____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

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. At what time of day or night do they occur?
   _____bedtime _____number per day
   _____just after waking _____in the morning
   _____in the afternoon _____in the evening
   Other:_____
6. How long do they last?
   _____few seconds _____1 – 2 minutes
   _____20 – 30 seconds _____more than 2 minutes
   _____40 – 60 seconds _____other:_____
7. 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:_____

8. Is the onset: _____sudden (few seconds) _____gradual (up to a minute)

9. During the seizure:
Does your child bite her/his tongue? Yes No
Does your child we his/her pants? Yes No

10. Does your child remember these spells? Yes No

11. Does your child have a warning when a seizure is about to happen?
Yes No

12. How does he/she behave after seizures? Please mark all that apply:
_____resume activity _____confused for awhile
_____sleep _____become irritable
_____other:_____

13. What do you think has caused this type of seizures of spells?
Comments_____
Longest seizure remission: Date of onset:_____
Remission duration_____
Comments_____
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 family life?
_____financial
_____emotional
_____divorce or separation
_____discipline problems with siblings
_____acting out with other children
_____decrease in number of social activities
_____other

ETIOLOGY:
Onset age:_____

_____unknown _____encephalopathy
_____head injury _____brain mass/tumor
_____malformation _____other (please describe)
_____infectious

Has the child been diagnosed with:

_____Sturge Weber _____Lennox-Gasteau Syndrome
_____Landau Kleffner Syndrome _____Tuberous Sclerosis
_____Cortical Dysplasia _____Partial/Agenesis of Corpus Callosum
_____Schizencephaly _____Encephalopathy
_____Hydrocephalus _____Other_____

Previous epilepsy surgical evaluation? Yes No

SECTION XIII: PREMATURITY AND NEWORN 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	
_____Congenital heart problems	describe:_____
_____Infections	describe:_____

Did your child receive:

_____ Intubation	
_____Oxygen	
_____Surfactant	
_____Antibiotics	types:_____
_____Chest tube	when:_____
_____Umbilical catheters	when:_____
_____Surgeries	when:_____
	detail:_____
_____Incubator	when:_____
	detail:_____

POST NEWBORN INTENSIVE CARE UNIT 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 XIV: ADDENDUM: ACCIDENT/INJURY
Complete this section if your child experienced accidents or illnesses when 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 rating at scene? 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

Glasgow coma rating 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:_____
_____SPECT Specify:_____ by:_____

_____Neurological evaluations
Date:_____ by:_____
_____Other, please explain_____
_____
_____

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

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

_____Nausea
_____Vomiting
_____Ringing in ears
_____Blurred vision
_____Aggression
_____Sexually acting out
_____Fainting/blackouts
_____Memory problems
_____Depression
_____Pain
_____Socially awkward
_____Anxiety

_____Decreased attention
_____Easily fatigues
_____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

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

Please use this space below to share any concerns that were not covered through your use of this form: