Touro University Nevada
Center for Autism and Developmental Disabilities

874 American Pacific Drive
Henderson, NV 89014
702.777.4808

CHILD NEUROPSYCHOLOGICAL HISTORY

Child's Name: _____ Date: _____

Address (Street, City, State, Zip): _____

Parent's or guardian's phone: (H) _____ (W) _____

Age _____ Birthdate _____ Religion _____

Sex _____ Ethnic or racial background _____

School and Grade _____

Special Placement (if any) _____

Hand child uses for writing or drawing: Right _____ Left _____ Switches between them _____

Primary language _____ Secondary language _____ Non-verbal _____

Medical diagnosis (if any) (1) _____

(2) _____

(3) _____

(4) _____

Who referred the child for this evaluation and/or service? _____

Primary Care Physician: _____ Phone: _____

(Authority to Release Patient Health Information between CADD & physician must be signed by parent.)

Briefly describe the problem(s)

(1) _____

(2) _____

(3) _____

(4) _____

What specific questions would you like answered by this evaluation?

(1) _____

(2) _____

(3) _____

(4) _____

THIS FORM HAS BEEN COMPLETED BY:

Name _____Relationship to child _____

Address _____

Phone (H) _____ (W) _____ (C) _____

SYMPTOM SURVEY

For each symptom that applies to the child, place a check in the box. Compare the child to other children of the same age. Then, check if this is a NEW symptom (within the past year OR after the injury/illness) or an OLD symptom (over one year OR before the injury or illness). Add any comments next to the item.

1) PROBLEM SOLVING

√	New	Old	
❑	___	___	Difficulty figuring out how to do new things
❑	___	___	Difficulty making decisions
❑	___	___	Difficulty planning ahead
❑	___	___	Difficulty solving problems a younger child can do
❑	___	___	Disorganized in his/her approach to problems
❑	___	___	Difficulty understanding explanations
❑	___	___	Difficulty doing things in the right order (sequencing)
❑	___	___	Difficulty verbally describing the steps involved in doing something
❑	___	___	Difficulty completing an activity in a reasonable period of time
❑	___	___	Difficulty changing a plan or activity when necessary
❑	___	___	Is slow to learn new things
❑	___	___	Difficulty switching from one activity to another activity
❑	___	___	Easily frustrated
❑	___	___	Other problem solving difficulties _____

2) SPEECH, LANGUAGE, AND MATH SKILLS

√	New	Old	
❑	___	___	Difficulty speaking clearly
❑	___	___	Difficulty finding the right word to say
❑	___	___	Not talking
❑	___	___	Rambles on and on without saying much
❑	___	___	Jumps from topic to topic
❑	___	___	Odd or unusual language or vocal sounds
❑	___	___	Difficulty understanding what others are saying
❑	___	___	Difficulty understanding what h/she is reading
❑	___	___	Difficulty writing letters or words
❑	___	___	Difficulty reading letters or words
❑	___	___	Difficulty with spelling
❑	___	___	Difficulty with math
❑	___	___	Other speech, language, or math problems: _____

3) SPATIAL SKILLS

√	New	Old	
❑	___	___	Confusion telling right from left
❑	___	___	Has difficulty with puzzles, Legos, blocks, or similar games
❑	___	___	Problems drawing or copying
❑	___	___	Doesn't know his/her colors

❑	___	___	Difficulty dressing (not due to physical disability)
❑	___	___	Problems finding his/her way around places he/she has been to before
❑	___	___	Difficulty recognizing objects
❑	___	___	Seems unable to recognize facial or body expressions of disapproval or emotions
❑	___	___	Gets lost easily
❑	___	___	Other spatial problems: _____

4) AWARENESS AND CONCENTRATION

√	New	Old	
❑	___	___	Easily distracted by: Sounds ___ Sights ___ Physical Sensations ___
❑	___	___	Mind appears to go blank at times
❑	___	___	Loses train of thought
❑	___	___	Difficulty concentrating on what others ay, but can sit in front of a TV for long periods
❑	___	___	Attention starts out OK but can't keep it up
❑	___	___	Other attention or concentration problems: _____

5) MEMORY

√	New	Old	
❑	___	___	Forgets where he/she leaves things
❑	___	___	Forgets things that happened recently (e.g., last meal)
❑	___	___	Forgets things that happened days/weeks ago
❑	___	___	Forgets what he/she is supposed to be doing
❑	___	___	Forgets names more than most people do
❑	___	___	Forgets school assignments
❑	___	___	Forgets instructions
❑	___	___	Other memory problems _____

6) MOTOR AND COORDINATION

√	New	Old		Check the side this occurs on: Right	Left	Both Sides
❑	___	___	Poor fine motor skills (e.g., using a pencil or crayon)	___	___	___
❑	___	___	Clumsy	___	___	___
❑	___	___	Weakness	___	___	___
❑	___	___	Tremor	___	___	___
❑	___	___	Muscles are tight or spastic	___	___	___
❑	___	___	Odd movements (posturing, peculiar hand movements, etc.)	___	___	___
❑	___	___	Drops things more than most children			
❑	___	___	Has an unusual walk			
❑	___	___	Problems running			
❑	___	___	Balance problems			
❑	___	___	Other motor or coordination problems: _____			

7) SENSORY

√	New	Old		Check the side this occurs on: Right	Left	Both Sides
❑	___	___	Needs to squint or move closer to page to read	___	___	___
❑	___	___	Problems seeing objects	___	___	___
❑	___	___	Loss of feeling			
❑	___	___	Problems hearing sounds			
❑	___	___	Difficulty telling hot from cold			
❑	___	___	Difficulty smelling odors			
❑	___	___	Difficulty tasting food			
❑	___	___	Overly sensitive to: Touch ___ Light ___ Noise ___			
❑	Other sensory problems: _____					
❑						

8) PHYSICAL

√	New	Old		How often?
❑	___	___	Frequently complains of headaches or nausea	_____
❑	___	___	Has dizzy spells	_____
❑	___	___	Has pains in joints. *Where?* _____	
❑	___	___	Excessive tiredness	
❑	___	___	Frequent urination or drinking	
❑	___	___	Other physical problems: _____	

9) BEHAVIOR

√	New	Old	
❑	___	___	Aggressive
❑	___	___	Attached to things, not people
❑	___	___	Bedwetting
❑	___	___	Bizarre behavior
❑	___	___	Bowel movements in underwear
❑	___	___	Dependent
❑	___	___	Depressed
❑	___	___	Eating habits are poor
❑	___	___	Emotional
❑	___	___	Fearful
❑	___	___	Immature
❑	___	___	Nervous
❑	___	___	Nightmares, night terrors, sleepwalks
❑	___	___	Quiet
❑	___	___	Resists change
❑	___	___	Risk-taking
❑	___	___	Self-mutilates
❑	___	___	Self-stimulates
❑	___	___	Shy and withdrawn
❑	___	___	Sleeping habits are poor
❑	___	___	Swears a lot
❑	___	___	Unmotivated
❑	___	___	Other unusual behavior _____

Below, check all the descriptions of the child that have been present for at least the **past 6 months**. These behaviors should occur more frequently than in other children of the same age.

_____ Careless
_____ Easily distracted
_____ Has a hard time concentrating for long periods
_____ Rarely follows others' instructions
_____ Doesn't listen to other people
_____ Goes from one activity to another without finishing anything
_____ Seems like he/she frequently is losing things that are needed for school
_____ Forgetful in daily activities
_____ Seems disorganized
_____ Very fidgety
_____ Can't remain seated
_____ Can't wait for his/her turn when playing with others
_____ Answers before he/she hears the whole question
_____ Frequently makes noise when playing
_____ Seems like he/she is always talking
_____ Is often rude or interrupts others
_____ Seems like driven by a motor
_____ Can't seem to play quietly

_____ Frequently does dangerous things without considering the consequences
_____ Loses temper easily
_____ Argues with adults
_____ Refuses to comply with requests
_____ Easily blames others for mistakes and problems
_____ Easily annoyed or irritated
_____ Seems angry and resentful
_____ Steals things without people knowing on several occasions
_____ Often runs away from his parents' home and stays away overnight
_____ Easily lies to others
_____ Fire setting
_____ Doesn't go to school
_____ Breaks into other people's property
_____ Destroys other people's property in some manner other than by fire
_____ Is cruel to animals
_____ Has forcible sexual relation with others
_____ When fighting, has used a weapon on more than one occasion
_____ Starts fights with others
_____ Will steal directly from people
_____ Is cruel to other people

10) Overall, the child's symptoms have developed: _____ Slowly _____ Quickly

11) The symptoms occur: _____ Occasionally _____ Often

12) Over the past 6 months the symptoms have: _____ Stayed about the same _____ Worsened

PREGNANCY

13) Mother's age at birth: _____ Father's age at birth: _____

14) **Before** the pregnancy, what medications (prescribed or over-the-counter) did the mother take?
List all medications used: _____

15) **While** pregnant, what medications (prescribed or over-the-counter) did the mother take?
List all medications used: _____

16) How often did the mother see her doctor during the pregnancy?
Regularly (as scheduled by the doctor) ____ Rarely ____ Not at all ____

17) During the pregnancy, which of the following did the mother use?

		Amount and Daily Frequency
____	Alcohol	_____
____	Caffeine (coffee, colas, etc.)	_____
____	Marijuana	_____
____	Recreational drugs (cocaine, heroin, etc.)	_____
____	Tobacco	_____

18) During pregnancy, the mothers diet was: Good ____ Poor ____
If poor, explain: _____

19) The mother's general physical health during the pregnancy was: Good ____ Poor ____
If poor, explain: _____

20) About how much weight did the mother gain while she was pregnant? _____ lbs.

21) During this pregnancy, check all the mother had:
_____ Accident
_____ Anemia
_____ Bleeding (severe or frequent spotting)
_____ Diabetes
_____ High blood pressure
_____ Illnesses or infections
_____ Preeclampsia, eclampsia, or toxemia
_____ Psychological problems
_____ Surgery
_____ Vomiting (severe or frequent)

22) How many pregnancies did the mother have prior to this one?
Number of live births: _____
Number of miscarriages: _____
Number of abortions _____

BIRTH

23) The child was born:
Early ____ How early? _____ weeks
On time ____ (38-42 weeks)
Late ____ How late? _____ weeks

24) How much did the baby weigh at birth? _____ lbs. _____ oz. OR _____ gms

25) How long did the labor last? _____

26) The labor was: Easy _____ Moderately difficulty _____ Very difficult _____

27) What type of medication was the mother given to help with delivery? None _____
Demerol ___ Gas ___ Regional nerve (spinal) block _____ Tranquilizer ___ Epidural ____

28) Were forceps used during delivery? Yes ____ No ____

29) Was the baby born:
Head first ____ Transverse (crosswise) ____ Posterior first ____
Breech birth ____ Caesarean section ____ Vacuum extraction ____
Other: _____

30) Did the baby experience any of these problems:
Fetal distress _____ Low placenta (Placenta previa) _____ Prolapsed cord _____
Premature separation of the placenta (Abruptio placenta) _____

31) Describe any other special problems the mother or child had during delivery:
_____
_____

32) At birth, did the baby:
Have difficulty breathing? Yes ___ No ___
Fail to cry? Yes ___ No ___
Appear Inactive? Yes ___ No ___

33) List the baby's Apgar scores: 1st _____ 2nd _____

34) If the father or mother noticed anything unusual when they first saw the baby, describe:
_____
_____

35) If the baby was born with any problems (congenital defects, large or small head, blue baby, bleeding in brain, etc.), describe: _____
_____

36) Describe any special problems that the baby had in the first few days or weeks following birth:
_____
_____

37) Describe any special care, treatment, or equipment the child was given after birth:
_____

38) How long did the baby stay in the hospital? _____

DEVELOPMENTAL HISTORY

39) For each area, indicate the child's development by circling one description. The "Average" period is only a rough idea of what is average since every developmental milestone actually involves a range of several months (e.g., walking occurs approximately 9-18 months of age). Circle "Early" or "Late" only if you are sure the child's development was typically different from that of most other children.

GROSS MOTOR SKILLS

Crawled	Early	Average (6-9 months)	Late
Walked alone (2-3 steps)	Early	Average (9-18 months)	Late
Pedals a tricycle	Early	Average (32-26 months)	Late

LANGUAGE

Followed simple commands	Early	Average (12-18 months)	Late
Used single-word	Early	Average (12-24 months)	Late
Said phrases	Early	Average (24-36 months)	Late
Names primary colors	Early	Average (36 to 48 months)	Late

ADAPTIVE

Toilet trained	Early	Average (13-36 months)	Late
Feeds self with spoon	Early	Average (21-24 months)	Late
Takes off open shirt/coat	Early	Average (18-24 months)	Late

40) List any other significant developmental problems:
_____
_____

41) Overall, the child's development was:
Early ____ Average ____ Late ____

42) As an infant or toddler, did the child have poor muscle control (i.e., weakness) of the:
Neck ____ Trunk ____ Legs ____ Arms ____

43) As an infant or toddler, did the child's muscles seem to be unusually tight or stiff?
Yes ___ No ____ If yes, describe: _____

44) Toilet training was: Easy ____ Difficult ____

45) As an infant, to a significant degree, was any of the following present during the first two years of life?

Did not enjoy cuddling	____
Was not calmed by being held or stroked	____
Difficult to comfort	____
Colic	____
Excessive restlessness	____
Poor sleep	____
Head banging	____
Difficult nursing	____

46) Please rate the following behaviors as you child appeared during infancy and toddlerhood:

Activity Level – How active has your child been from an early age? _____

_____

Distractibility – How well did your child pay attention? _____

_____

Adaptability – How well did your child deal with transition and change? _____

_____

Approach/Withdrawal – How well did your child respond to new things (i.e. people and places)?

_____

Mood – What was your child's basic mood? _____

_____

Regularity – How predictable was your child in patterns of sleep, appetite, routines, etc.? _____

_____

HEALTH HISTORY

47) Did the child have a good appetite as a baby? Yes ___ No ___

48) Did the child fail to gain weight steadily as a baby? Yes ___ No ___

49) List the baby's illnesses or physical problems during the first year:

_____

50) Has the child had a temperature of 104°F (40°C) or higher for more than a few hours?

Yes ___ No ___ If yes, what age(s)? _____ and how long did it last? _____

51) Has the child ever been hit hard on the head or suffered a head injury? Yes ___ No ___

If yes, what age(s)? _____ Did the child lose consciousness? Yes ___ No ___

How did it happen? _____

What problems did the child have (physical or mental) afterwards?

_____

_____

52) Has the child been diagnoses with seizures or epilepsy?

If yes, which type? Partial seizure ___ Generalized seizure ___ Unclassified type ___

If medication is used, what medication(s)? _____

Has the child ever had a bad reaction to this medicine? Yes ___ No ___

If yes, describe: _____

Did the child ever have a seizure due to a fever or unknown cause? Yes ___ No ___

If yes, describe (age, nature of seizure): _____

53) Was the child ever in the hospital for an accident, injury, or operation? Yes ___ No ___

If yes, what age(s)? _____ What happened? _____

_____

_____

54) Has the child ever swallowed any poison, non-food, or drug accidentally? Yes ___ No ___
If yes, what age(s)? _____ What happened? _____

55) Did the child have frequent ear infections? Yes ___ No ___
If yes, what age(s)? _____ How often and severe? _____
What treatment was provided? _____

56) Please check all of the following diseases or conditions your child has ever had:

___	Allergies	___	Cerebral Palsy	___	Jaundice	___	Mumps
___	Anemia	___	Chicken Pox	___	Kidney Disorder	___	Oxygen deprivation
____	Asthma	___	Colds (excessive)	___	Leukemia	___	Pneumonia
____	Bleeding disorder	___	Diabetes	___	Liver disorder	___	Rheumatic fever
____	Blood disorder	___	Encephalitis	___	Lung Disorder	___	Scarlet fever
____	Brain disorder	___	Enzyme deficiency	___	Measles	___	Tuberculosis
____	Broken bones	___	Genetic disorder	___	Meningitis	___	Venereal disease
____	Cancer	___	Heart disorder	___	Metabolic disorder	___	Whooping cough
____	Eye problems	___	Tics (eye blinking, sniffing, and repetitive movement)				
____	Other problems _____						

57) As the child has been growing up, he/she has been sick:
Much of the time ____ An average amount ____ Not much at all ____

58) List all the medications the child takes now:

Medication	Dosage	How often?	What for?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

59) Does the child?
Wear glasses? Yes ___ No ___ (Farsighted ___ Nearsighted ___ Other ____ Specify _____)
Use a hearing aid? Yes ___ No ___

60) Within the past year has the child had:

			RESULTS
A vision test?	Yes ___	No ___	_____
A hearing test?	Yes ___	No ___	_____

61) What is the child's: Height: _____ ft. _____ in. Weight: _____ lbs.

62) When was the child's last medical checkup? _____

63) What therapies have been provided to the child? _____ No therapies
_____ Occupational therapy
_____ Physical therapy
_____ Psychological therapy, counseling, or cognitive rehabilitation
_____ Speech therapy
_____ Other therapy _____

FAMILY HISTORY

64) The child lives with:
___ Biological parent(s) only ___ Relatives ___ Foster parents
___ Biological parent and other ___ Adoptive parents ___ Institutional care
___ Other placement _____
Please list all the people currently living in the home with the child and their relation to the child (include family and nonfamily members) _____
_____

65) The family's income is:
under $10,000 ___ $10,000-29,999 ___ $30,000-50,000 ___ over $50,000 ___

66) What is the name of the child's biological mother? _____
a. Is she living? Yes ___ No ___ If deceased, explain: _____
b. Her age? _____
c. What is her level of education? _____
d. Her occupation? _____
If mother works outside the home, how many hours and what days did she work _____
e. Does she live in the same house as the child? Yes ____ No ____
f. If not, how often does she see the child? _____
g. How involved is the mother in the child's upbringing? Very ___ Somewhat ___ Not at all ___
h. During school, the mother had:
Learning problems _____
Attention problems _____
Behavior problems _____
Medical problems _____
i. What are the mother's hobbies? _____
j. What is mother's primary language _____ Secondary language _____

67) What is the name of the child's biological father? _____
a. Is he living? Yes ___ No ___ If deceased, explain: _____
b. His age? _____
c. What is his level of education? _____
d. His occupation? _____
If father works outside the home, how many hours and what days did he work_____
e. Does he live in the same house as the child? Yes ____ No ____
f. If not, how often does he see the child? _____
g. How involved is the father in the child's upbringing? Very ___ Somewhat ___ Not at all ___
h. During school, the father had:
Learning problems _____
Attention problems _____
Behavior problems _____
Medical problems _____
i. What are the father's hobbies? _____
j. What is father's primary language _____ Secondary language _____

68) Please list the names, ages, and grade (or job) of the child's brothers and sisters:

Name	Age	Grade or job	Medical, Social, and/or School Problems
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

69) Has anyone in the child's biological family (including parents, grandparents, siblings, aunts, and uncles) ever had any of the following?

		Which relative?	Describe the problem briefly
____	Brain disease	_____	_____
____	Developmental Delay	_____	_____
____	Epilepsy or seizures	_____	_____
____	Learning disability	_____	_____
____	Mental retardation	_____	_____
____	Neurologic disease	_____	_____
____	Psychological problems	_____	_____
____	Reading/spelling difficulties	_____	_____
____	Speech/language problems	_____	_____

70) Which of the child's biological relatives are left-handed? No one _____
Mother ____ Father ____ Sibling(s) _____ Grandparents ____

71) What languages are spoken in the home? (List in order of most frequent first)
(1) _____ (2) _____

72) How is the child disciplined? _____
_____
Is the discipline effective? _____

73) List the child's usual recreational activities and hobbies: _____
_____
_____

74) Have there been any major family stresses or changes in the past year (e.g., moving with change of school, divorce, significant illness, etc.)? Yes ___ No ___
If yes, explain: _____
_____
_____

How much stress has these changes caused the child? (circle one)
None Mild Moderate Severe

75) Does the child attend day care outside the home or does someone come into the home to provide the service?
_____
Does day care provide any type of formal program of play, developmental, or academic activities?
_____
_____

PEER RELATIOHSIPS

76) Does your child seek friendships with peers? _____
_____
77) Is your child sought by peers for friendship?_____
_____
78) Does your child play with children primarily his or her own age ? _____
Younger? _____ Older? _____
79) Describe any problems your child may have with peers _____
_____

SCHOOL HISTORY

80) The child's present school is: Name _____
Address _____
Phone _____ Contact person _____

81) Was the child ever held back to repeat a grade? Yes ___ No ___
If yes, which grade? _____ Why? _____
_____

82) Has the child ever been in a special class or provided with special services (e.g., RSP, Self-contained day class, learning or language disability class, etc.) Yes ___ No ___
If yes, describe the special class _____
_____
Is the child in this class or receiving special services now? Yes ___ No ___

If yes, describe the present class placement _____
_____

83) Does the child like school? Most of the time ___ Sometimes ___ Almost never ___

84) Does the child:
Have problems with other children in class? Yes ___ No ___
Have problems making friends in school? Yes ___ No ___
Have problems getting along with teachers? Yes ___ No ___
Tend to get sick in the morning before school? Yes ___ No ___

85) Describe the teacher's concerns about the child's schoolwork or behavior:
_____
_____

86) What kind of grades has the child received in the past year?
A's & B's ____ B's & C's ____ C's & D's ____ D's & F's ____
-Or-
Outstanding ___ Good ____ Satisfactory ___ Improvement needed ___ Unsatisfactory ___
-Or-
Other grading system _____
Are these grades a change from previous years? Yes ___ No ___
If yes, describe _____
_____

87) In which subject(s) does the child do best? _____
_____

88) Which subject(s) are the most difficult? _____
_____

89) In the past year, how much school has the child missed due to illness or injury?
Less than 2 weeks ___ 2-4 weeks ___ 5-8 weeks ___ Over 8 weeks ___
Briefly describe the reasons if the child has missed a lot of school:
_____
_____

90) Does the child seem to have a "school phobia?" Yes ___ No ___
If yes, explain: _____

91) Do you consider your child to understand directions and situations as well as other children his or her age?
_____
_____
_____

92) How would you rate your child's overall intelligence compared to other children?
Below average _____ Above average _____ Average _____

PREVIOUS EVALUATIONS

93) Which of these tests or procedures has recently has been done? Note if normal or abnormal

Evaluation	Normal	Abnormal	Date
___ Blood work	_____	_____	_____
___ Family physician or pediatrician office visit	_____	_____	_____
___ Hearing testing	_____	_____	_____
___ Lead level check	_____	_____	_____
___ Lumbar puncture or spinal tap	_____	_____	_____
___ Neurological examination or testing (CT scan, EEG)	_____	_____	_____
___ Psychological or Neuropsychological testing	_____	_____	_____
___ School testing	_____	_____	_____
___ Speech & Language testing	_____	_____	_____
___ Vision testing	_____	_____	_____
___ X-rays	_____	_____	_____
___ Other tests:			
_____	_____	_____	_____
_____	_____	_____	_____

94) What are the names of the physician, psychologist, school authority, or other professionals who are most familiar with the child's problems?

Name _____
Address _____
_____
Phone _____
Profession _____

Name _____
Address _____
_____
Phone _____
Profession _____

Please Note: If your child has seen a psychologist at any time in the last year for testing or treatment, please be sure to advise the doctor.

ADDITIONAL COMMENTS: Please note below any further information you feel may be helpful in the evaluation of your child.

_____
_____
_____
_____
_____

_____ _____
Parent or Guardian's Signature Date

THANK YOU FOR TAKING THE TIME TO CAREFULLY COMPLETE THIS QUESTIONNAIRE.