S. W. ZIMOSTRAD, Ph.D. AND ASSOCIATES

CLINICAL AND BEHAVIORAL NEUROPSYCHOLOGY

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CHILD HISTORY FORM

PARENTS, please take some time to complete this form **in its entirety**. Your responses to the following questions are very important and will allow us to gain a better understanding of your child and any current problems. We are aware that it may be difficult to remember certain dates and events – In such instances, please provide your best estimate.

– Please answer every question –

Parent Name: ____ Date: ____________________

Address: ____

Telephone: Home: ______________________ Work: ______________________

Date of Birth: ______________________ Current Age: ______________ Sex: ________

Child Name: ____ Date: ____________________

Primary Address/Residence: ____

Date of Birth: ______________________ Current Age: ______________ Sex: ________

Does the child have a legally appointed guardian? (If yes, give a full name, address, and telephone number)

____

____

Family Doctor: ______________________________ **Telephone:** ______________________

Address: ____

Is your child currently being seen by any other doctors? ❑ Yes ❑ No
If so, please provide:

Name: ______________________ Telephone: ______________________

Address: ____

Name: ______________________ Telephone: ______________________

Address: ____

Does your child have a case manager? ❑ Yes ❑ No
If so, please provide:

Name: ______________________ Telephone: ______________________

Address: ____

Who referred you to our Office?

Name: ______________________ Telephone: ______________________

Address: ____

Please clearly describe your current reasons for seeking an evaluation for your child:

____

____

____

____

Please describe any current symptoms:

____

____

____

____

Where do these symptoms affect your child the most?

- ❑ Home
- ❑ School
- ❑ Work
- ❑ All of the above

When did the current symptoms and/or concerns first start?

____

____

Does anyone else in your family have these same problems? Have any family members in the past had these same problems?

❑ Yes ❑ No

If so, please state who:

____

DEVELOPMENTAL HISTORY

Child's place of birth: ________________________________

Birth Weight: ___________________ pounds __________________ounces

Did the child's mother receive pre and postnatal care? ❑ Yes ❑ No

Where there any specific complications during pregnancy, labor, or delivery? ❑ Yes ❑ No

If yes, please describe:

____

____

Was your child exposed to any alcohol, tobacco, or other drugs during your pregnancy?

❑ Yes ❑ No

If yes, please describe/list:

____

____

At approximately what age did your child meet each of the following developmental milestones? (please do your best to provide your best answers to these questions).

- At what age did your child begin walking? _________________________________ months
- At what age did your child begin using single words ___________________________ months (momma, papa, puppy, etc.)?
- At what age did your child begin putting words together into simple phrases ________________________ months (Hi momma, love you, want that, etc.)?
- At what age was your child toilet trained? _________________________________

Were there any developmental delays that you were concerned about (For example: early problems walking or talking?)

❑ Yes ❑ No

If yes, please describe:

____

____

____

Did your child suffer any serious injuries or illnesses as an infant or child?

❑ Yes ❑ No

If yes, please describe:

____

____

____

MEDICAL HISTORY

Does the child have any medical conditions?

❑ Yes ❑ No

If yes, please describe:

Condition: ______________________________ When was this diagnosed? ____________________

❒ Resolved ❒ Ongoing

Condition: ______________________________ When was this diagnosed? ____________________

❒ Resolved ❒ Ongoing

Condition: ______________________________ When was this diagnosed? ____________________

❒ Resolved ❒ Ongoing

Condition: ______________________________ When was this diagnosed? ____________________

❒ Resolved ❒ Ongoing

Condition: ______________________________ When was this diagnosed? ____________________

❒ Resolved ❒ Ongoing

Has your child ever had a head injury? (Including concussions, traumatic brain injuries, skull fractures, brain swelling etc.)

❑ Yes ❑ No

If yes, please indicate the following:

Type of head injury: ______________________________ Year of the Injury: ____________
Were they medically evaluated following the head injury?
❑ Yes ❑ No

Type of head injury: ______________________________ Year of the Injury: ____________
Were they medically evaluated following the head injury?
❑ Yes ❑ No

Type of head injury: ______________________________ Year of the Injury: ____________
Were they medically evaluated following the head injury?
❑ Yes ❑ No

Type of head injury: ______________________________ Year of the Injury: ____________
Were they medically evaluated following the head injury?
❑ Yes ❑ No

Has your child ever lost consciousness? ❑ Yes ❑ No

If yes, please explain reasons why: (include dates when child lost consciousness)

____

____

____

Has your child ever had a seizure? ❑ Yes ❑ No

If yes, please explain:

When did the seizures start?____

How often do they occur?____

____

Has your child ever had any of the following procedures?

❑ MRI Year ____________ Results: ______________________________

- ❑ CT Scan Year _______________ Results: ____
- ❑ EEG Year _______________ Results: ____
- ❑ PET Scan Year _______________ Results: ____
- ❑ MEG Scan Year _______________ Results: ____

Please list any medications that your child is <u>currently</u> taking:

Medication: ____ Year prescribed: ________________

Medication: ____ Year prescribed: ________________

Medication: ____ Year prescribed: ________________

Medication: ____ Year prescribed: ________________

Medication: ____ Year prescribed: ________________

Medication: ____ Year prescribed: ________________

Medication: ____ Year prescribed: ________________

Please list any medications that your child has previously taken:

Medication: ____ When discontinued: ________________

Medication: ____ When discontinued: ________________

Medication: ____ When discontinued: ________________

Medication: ____ When discontinued: ________________

What is your child's appetite like? (please check the appropriate boxes)

- ❑ Appetite is generally good – No major changes
- ❑ Appetite is generally poor – don't eat very much
- ❑ Appetite changes a lot – Sometimes eats well, other times doesn't eat very much
- ❑ Picky eater – Very selective

What is your child's sleep like? (please check the appropriate boxes)

- ❑ Problems getting to sleep — These problems started in (year): ________________
- ❑ Problems staying asleep — These problems started in (year): ________________
- ❑ No current sleep problems – generally sleeps well.

Do they have any hearing or vision problems?

❑ Yes, wears hearing aids	❑ Yes, but doesn't have hearing aids	❑ No, hearing is fine
❑ Yes, wears glasses	❑ Yes, but doesn't have glasses	❑ No, vision is fine

EDUCATION AND EMPLOYMENT HISTORY

Current Grade (please circle): K 1 2 3 4 5 6 7 8 9
10 11 12 College

Are there any of the following problems in school?

❑ Problems paying attention	❑ Problems turning in work	❑ Problems with organization
❑ Hyperactive	❑ Problems with teachers	❑ Learning problems
❑ Behavior problems	❑ Problems with other students	

Is the child in any special education classes in school?

❑ Yes ❑ No

Was the child ever held back a grade?

❑ Yes ❑ No

If yes, which grade(s) were they held back in?

____ Current GPA ____________________

High school GPA ______________ College GPA ______________

Is the child/young adult currently employed?

❑ Yes ❑ No

If yes where?

Where: ______________________________ How long have they worked there? ____________

SOCIAL HISTORY

Check the box or boxes that best describes your child's current living situation

- ❑ Currently living with both biological parents
- ❑ Currently living with one biological parent
- ❑ Other (please explain): ____

Siblings? ❑ Yes ❑ No

If yes, please indicate the following:

Age ________ ❑ Male ❑ Female

Age ________ ❑ Male ❑ Female

Age ________ ❑ Male ❑ Female

Age ________ ❑ Male ❑ Female

Age ________ ❑ Male ❑ Female

Is there any family history of the following conditions? (check all that apply)

- ❑ Alzheimer's……………………………In who? ______________________________
- ❑ Dementia………………………………In who? ______________________________
- ❑ Parkinson's Disease ………………...In who? ______________________________
- ❑ Huntington's Disease………………In who? ______________________________
- ❑ Pick's Disease………………………In who? ______________________________
- ❑ Depression…………………………..In who? ______________________________
- ❑ Anxiety……………………………...In who? ______________________________
- ❑ ADD/ADHD………………………..In who? ______________________________
- ❑ Schizophrenia………………………In who? ______________________________
- ❑ Bipolar Disorder……………………In who? ______________________________

Please Describe your child's relationships with family members (any strained relationships?)

____

____

____

____

____

Is your child currently experiencing stress due to family problems, academic problems, traumatic events, or other causes? (if so, please describe)

____

____

____

____

What are some activities and interests your child currently enjoys/participates in? (leisure activities, hobbies, interests)

____

____

MENTAL HEALTH HISTORY

Has your child ever been hospitalized for psychological/psychiatric reasons? ❑ Yes ❑ No

If yes, please indicate the following:

Where: ______________________ When (year) ____________ How long? __________

Where: ______________________ When (year) ____________ How long? __________

Where: ______________________ When (year) ____________ How long? __________

Has your child ever had a psychological or neuropsychological evaluation before? ❑ Yes ❑ No

Have they ever been diagnosed with any of the following conditions?

- ❑ Depression
- ❑ Learning problems
- ❑ Bipolar Disorder
- ❑ Anxiety
- ❑ Obsessive Compulsive Disorder
- ❑ Anorexia or Bulimia

- ❑ ADD/ADHD
- ❑ PTSD (Post-Traumatic stress Disorder)
- ❑ Schizophrenia
- ❑ Borderline Personality Disorder

Are they currently seeing/working with a counselor or therapist? ❑ Yes ❑ No

If so, please provide:

Name: ____ Telephone: _______________________________

Address: ____

If yes, how long have they been seeing this therapist? ____

If yes, has this therapy been helpful? ____

<u>END</u>

Thank you for taking the time to respond to these questions. Your feedback and information is important, and will help us better understand any current problems that your child may be experiencing.

This form may be brought back in person or faxed to our office at
<u>(989) 839-5794</u>