# Pediatric Neuropsychological Services of Alaska, PC

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## Pediatric Questionnaire

Name: ______________________________ Date of Birth: ______________

Date of Evaluation: ______________

Name of person completing questionnaire: ____________________________________________________

Relationship to child: ______________________________________________________________________

Who recommended that you seek an evaluation at this time? ___________________________________

Reason for Seeking Evaluation

Current Problem *(use back of sheet if necessary)*

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Does the child have a medical condition, a neurological or developmental disorder, or a genetic syndrome?

_____________________________________________________________________________________

_____________________________________________________________________________________

Does the child have any behavioral and/or emotional problems? _______________________________

_____________________________________________________________________________________

Does the child have any learning or academic problems? _____________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Please describe the child's strengths. ____________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Please describe the child's weaknesses. __________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Family History

| *(Please list as appropriate)* | *Age* | *Gender* | *Birthweight* |
|---|---|---|---|
| This Child | ____________years | _______(M/F) | ____________________ |
| Brothers | ____________years | _______ (M/F) | ____________________ |
| and/or | ____________years | _______ (M/F) | ____________________ |
| Sisters | ____________years | _______ (M/F) | ____________________ |

Is this child: biological ? ________ adopted ?__________ a foster child ? ______________

other family member (grandchild, niece/nephew)? ______________________________

With whom does this child live at the present time? (Include parents, brothers, sisters, grandparents, friends, etc.)

__________________________________________________________________________

____________________________________________________________________________________

What supports do you currently have in raising your children? CHECK ALL THAT APPLY

O Maternal grandparents O Paternal grandparents O Brothers/spouses

O Sisters/spouses O Other relatives ________________________________________

O Friends O Religious community O Community group(s)

O Other ___________________________________________

What language(s) is (are) used at home? ____________________________________________________

What is mother's education (highest grade completed)? _________ her occupation?

___________________________________

What is father's education (highest grade completed)? __________ his occupation?

___________________________________

Please list anybody in the family who is left-handed or mixed handed ___________________________

____________________________________________________________________________________

Please list anybody in the family who has had learning problems in school:

| Person | Problem |
|---|---|
| (parents, grandparents, brothers, sisters, uncles, aunts, etc.) | (language, reading, writing, spelling, math, etc.) |
| _____________________________ | __________________________________________________ |
| _____________________________ | __________________________________________________ |
| _____________________________ | __________________________________________________ |
| _____________________________ | __________________________________________________ |

Please list anybody in the family who has had behavior problems:

| Person | Problem (overactive, restless, withdrawn, difficulties with the law, etc.) |
|---|---|
| ______________________ | ______________________________ |
| ______________________ | ______________________________ |
| ______________________ | ______________________________ |
| ______________________ | ______________________________ |
| ______________________ | ______________________________ |

Has anyone in the family ever been diagnosed with, or suffered from:

Seizures/epilepsy ______________________________

Other neurological disease or disorder ______________________________

(brain injury, stroke, dementia…) ______________________________

Emotional problems ______________________________

(anxiety, depression, bipolar disorder…) ______________________________

Mental retardation/developmental disability ______________________________

Birth History

Which (1st, 2nd, etc.) was this child of mother's pregnancies? ______________________________

Age of mother at delivery ____________ Age of father at delivery ________________

Was this child born (check one): premature_____ At the expected time______ Late______

Did your doctor note any problems with your pregnancy? labor? delivery? ________________

______________________________________________________________

______________________________________________________________

Medical History (Child)

Condition of child at birth ______________________________________________

Did child have jaundice, "Rh" problems, chemical abnormalities, etc? ______________

Has child had seizures, convulsions? ______________ If so, at what age? ____________

Were seizures/convulsions associated with a high fever? ________________________

Has child ever had a serious illness? If so, what? ______________________________

When? ____________________ For how long? ______________________

Has child ever been hospitalized? If so, why? ______________________________

When? ____________________ For how long? ______________________

Has child ever had any operations? If so, what? ______________________________

When? ______________________________________________

Does the child have any allergies? If so, what is s/he allergic to? ________________________

________________________________________________________________________________

Has your child ever had any head injuries? If so, when ?__________________________________

What happened? ____________________________________________________________

Was child unconscious? ______ dizzy? _______Did child have a headache? _____________

Was the child seen by a physician ? ______________________________________________

How often does child have abdominal pain/vomiting?______________________________________

When does this occur? ________________________________________________________

How often does child have headaches? ___________________________________________________

How are these treated? _______________________________________________________

Does child have vision problems? (please specify) ______________________________________

Does child have hearing problems? (please specify) _____________________________________

Has child had a history of frequent ear infections? _____________________________________

If so, how often? _____________________ When? ________________________________

**Please list all medications the child currently takes**______________________________________

________________________________________________________________________________

Developmental History:

As an infant, was this child fussy/difficult to comfort? _______"sickly"? _______

over-sleepy/difficult to rouse? ___________________

Compared to other children, did this child have difficulty learning:

To talk? _____________________ To understand? ___________________________________

Gross motor skills (walking, talking, hopping, riding bike, etc.)?________________________

Fine motor skills (fastening buttons, zippers, drawing, etc.)?___________________________

Early school related skills (colors, alphabet, etc.) ?___________________________________

To play/socialize with other children? ____________________________________________

To build with blocks, play with puzzles, etc? ______________________________________

Has the child had difficulty in separating? ______________________ At what age? ______________

When was the child toilet trained for day? ______________________ For nights? ________________

Has this child had any sleeping difficulties? _______________________________________________

Has this child had any eating difficulties? ________________________________________________

Which hand does he/she prefer? for writing? ____________ for sports? ________________________

When did s/he show a clear hand preference ? ____________________________________

Does this child play with older, younger or same age children? ______________________________

Does this child have the opportunity to play with children the same age? _________________

Does this child have any hobbies, and/or participate in clubs, organizations, etc.?_________________

______________________________________________________________________________

What family responsibilities/chores does this child have? ___________________________________

Has this child ever had psychotherapy/counseling? _________________________________________

School History:

What grade is child presently in? _______ Has s/he ever repeated a grade? ________

Which? _________

What schooling, if any, did this child have prior to first grade? (please specify) ___________________

______________________________________________________________________________

Did child have a pre-kindergarten screening? _______________________________________________

If so, did he/she pass? _________________________________________________________

In which grade did school problems become noticeable? (where appropriate)

______________________________________________________________________________

Has your child ever received special educational services in school ? YES NO

If so, which grades ? ___________ What services have been provided? ___________________

______________________________________________________________________________

Does your child currently have an Individualized Educational Plan? ______or a 504 plan?____(check one)

Does child have resource room help now? YES NO

If so, for which academic skills? ____________________________ how often? _____________

Has child had frequent change of school? YES NO

If YES, why? __________________________________________________________________

What is the child's present school? (please give full address)

Name: ______________________________________________________________________

Street: ______________________________________________________________________

City/State/Zip: ________________________________________________________________

Who is the appropriate contact person for details of the child's schoolwork?

Name _______________________________ Position _______________________________________

How long has s/he known the child/ _____________________________________________________

Is there any other information about the child and his/her family circumstances, development or medical condition that you would like the neuropsychologist to know?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
______________________________________________________________________

Health Care Insurance

Insurance Company ____________________________________________________

Contact Name & Number ____________________________________________________

____________________________________________________

_____________________________________________________________________________

Signature of Parent/Guardian

_____________________________________________________________________________

Address (*street, town, state, zip*)

_______________________________ Best time to contact _____________________________________

Phone Number

Date ___________________________

**Please bring any reports of psychological or educational evaluations that are available.**