PNS
Pediatric Neuropsychological Services

Neuropsychology Pediatric Medical History Questionnaire

The following questions are designed to provide us with information about your child's medical history, especially as it pertains to current neurological and psychiatric health. Please answer all questions as accurately and completely as possible. You will have a chance to discuss answers in detail with the doctor. Thank you!

Today's Date: _____

Name of person completing form: _____ Relationship: _____

Phone Number: _____ Email: _____

Referring Provider: _____ Specialty: _____

I. Child's Demographic Information

Name: Last_____ First_____ MI _____

Date of Birth: Month_____Date_____Year_____Age_____

Race/Ethnicity: _____ Gender: _____ Native language: _____

Name of School: _____ Current grade: _____

Are you considering or involved in any lawsuits or litigation (circle one): Yes / No / Considering

If so, please briefly explain: _____

II. Presenting Concern

Briefly state the main concern or problem that brings the child to PNS:

_____

_____

_____

III. Pregnancy and Birth

Is this child adopted (circle one)? Yes / No If so, at what age: _____

Where was the child born and raised? _____

Duration of pregnancy (weeks): _____ Did the child's mother receive prenatal care (circle one): Yes / No

Were there any complications with pregnancy (please check all that apply):

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- ☐ Accidents or injuries
- ☐ Blood clots
- ☐ Excessive staining/blood loss
- ☐ Excessive vomiting
- ☐ Gestational diabetes
- ☐ High blood pressure
- ☐ High or Low amniotic fluid
- ☐ Hospitalizations
- ☐ Infections
- ☐ Iron deficiency
- ☐ Maternal illness
- ☐ Placenta previa
- ☐ Placental abruption
- ☐ Preeclampsia
- ☐ Rh Factor negative
- ☐ Small for gestational age (SGA) / Intrauterine growth restriction (IUGR)
- ☐ STD/STI
- ☐ Threatened miscarriage
- ☐ Toxemia
- ☐ Other: _____

_____

Smoking or tobacco use during pregnancy (circle one): Yes / No If so, number of cigarettes per day: ____

Alcohol use during pregnancy (circle one): Yes / No / DK If so, amount: _____ / week.

Medications during pregnancy: _____

X-Rays during pregnancy: _____ Other: _____

IV. Delivery

Type of delivery (check one): _____ Natural _____ Cesarean (indicate reason): _____

Was labor: _____ Spontaneous or _____ Induced? Length of labor: _____

Were there any delivery complications (check all that apply):

- ☐ Baby's shoulder stuck
- ☐ Breech
- ☐ Cord around neck
- ☐ Fetal distress
- ☐ Forceps / vacuum assist
- ☐ Hemorrhage
- ☐ Labor did not progress
- ☐ Meconium aspiration
- ☐ Problems with baby's muscle tone or movement
- ☐ Rapid labor
- ☐ Umbilical cord compressed or stretched
- ☐ Water broke early
- ☐ Other : _____

Birthweight: _____ lbs. _____ oz. Apgar scores (if known): _____ and _____

Were there any findings with newborn screening tests: Yes / No (Indicate): _____

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V. Post-Delivery

Were there any complications post-delivery? (please check all that apply)

- ☐ Cyanosis (turned blue)
- ☐ Infection: _____
- ☐ Resuscitation
- ☐ Jaundice
- ☐ Trouble breathing
- ☐ Other: _____

Did this child require NICU placement: Yes / No If so, how long? _____

Did this child require any NICU supports (e.g., ventilator)? Yes / No Please indicate: _____

After how many days after birth was this child discharged home? _____

Were there any difficulties with feeding (e.g., latching, sucking, swallowing) or weight gain? Yes / No

If so, please indicate: _____

VI. Medical

General Medical History. Please check the box next to any current or previous medical conditions:

- ☐ Allergies please indicate:
  - Seasonal
  - Specific: _____
- ☐ Autoimmune disease
- ☐ Broken Bones
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Diabetes
- ☐ Exposure to toxins (e.g., lead, mercury)
- ☐ Genetic Disorder
- ☐ Headache or Migraine
- ☐ Heart Problems
- ☐ High or Prolonged Fever (>104)
- ☐ HIV
- ☐ Hypertension
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Metabolic Disorder
- ☐ Seizures (please complete seizure questions on the next page)
- ☐ Serious Infections (e.g., meningitis, encephalitis)
- ☐ Thyroid or other endocrine disorder
- ☐ Urinary Incontinence
- ☐ Vitamin Deficiency
- ☐ Head Injury or Concussion
  - Was there loss of consciousness? Yes / No
  - If so, how long: _____
- ☐ Other (please use space below)

Other medical problems: _____

_____

_____

Please list any surgeries or procedures including ages:

Surgery/Procedure	Age

Please list the names and dosages of all medications:

Medication Name	Dosage (include how many times per day)	Length of time the child has been taking this medication	Who prescribed this medication (e.g., pediatrician, psychiatrist)

Has the child ever undergone any of the following (check all that apply):

	Skull x-ray	Age:	Results:
	EEG	Age:	Results:
	CT Scan	Age:	Results:
	MRI Scan	Age:	Results:
	PET Scan	Age:	Results:
	SPECT Scan	Age:	Results:
	Spinal Tap	Age:	Results:

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Date of last physical: _____

Please check the box next to any assistive devices the child currently uses:

- ☐ Glasses
- ☐ Reading glasses
- ☐ Contact Lenses
- ☐ Hearing Aid
- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Other: _____

Sleep:

How many hours of sleep does the child get per night? _____ Does s/he wake up refreshed? Yes / No

Does s/he use an assistive device for sleep (e.g., CPAP)? Yes / No If so, what type? _____

Are there any concerns for sleep behaviors (e.g., sleep walking, thrashing, acting out dreams)? Yes / No

If yes, please indicate: _____

Appetite:

Have there been any changes in this child's appetite (increased or decreased)? Yes / No _____

VII. Neurodevelopmental History

At what age did the child:

Sit independently: _____

Crawl: _____

Take first steps: _____

Use single words: _____

Use two-word phrases: _____

Use sentences: _____

Become toilet trained during the day: _____

Become toilet trained at night: _____

Does the child have any problems in the following areas? (check all that apply)

- ☐ Walking
- ☐ Running
- ☐ Throwing
- ☐ Catching
- ☐ Clumsiness
- ☐ Buttoning
- ☐ Tying
- ☐ Attention
- ☐ Activity level
- ☐ Speech
- ☐ Depression
- ☐ Anxiety

Hand child writes with: _____ Hand child eats with: _____ Hand child throws with: _____

Did this child receive any intervention to facilitate development of skills (e.g., Speech Therapy, Occupational, Physical)? If so, please indicate: _____

_____

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As an infant and toddler (ages 0-3), did the child/was the child (check all that apply):

- ☐ Able to "go with the flow"
- ☐ Difficult to nurse or feed
- ☐ Difficult to sleep
- ☐ Difficult to soothe
- ☐ Easy to please
- ☐ Interested in people
- ☐ Irritable/Cranky/Fussy
- ☐ Made eye contact
- ☐ Overly active
- ☐ Smiled at caregivers

Were there any other concerns as an infant or toddler? _____

_____

VIII. Social-Emotional History

Do you have any concerns about this child's play skills (curiosity about the environment, pretend play, playing with other children, unusual behaviors in play)? If yes, please describe: _____

_____

Does this child prefer to play with: _____ younger children _____ same age _____ older children?

How many close friends does this child have? _____

Describe how this child gets along/plays with other children: _____

_____

Describe how this child interacts with new children or children s/he has never met before: _____

_____

Describe how this child plays when alone: _____

Does this child seek to share new or interesting things with other people? Yes / No

Are there any concerns for preoccupation with toys, objects, or routines? Yes / No Please describe:

_____

How does this child react to changes in schedules or routines: No Problem / Mildly Upset / Very Upset

Does this child have any repetitive motor mannerisms such as hand flapping, finger wiggling, twirling, etc.? Yes / No Please describe: _____

_____What age did these begin? _____

Please list hobbies and interests: _____

_____

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IX. Educational History

Does or did this child attend preschool or daycare? ____ Yes ____ No If so, were there any concerns expressed by the preschool or daycare teacher? _____

_____

Were there any concerns about this child's pre-academic skills (letters, numbers, shapes, colors, drawing/writing, etc.)? If yes, please describe: _____

_____

Has this child ever been diagnosed with a learning disability or other neurodevelopmental condition (e.g., SLD, ADHD): Yes / No

If so, please indicate: _____

Has this child repeated any grades: Yes / No If so, please indicate: _____

Typical grades on report cards: _____

Does this child attend: regular classroom placement_____ or special placement _____? Please indicate: _____

Does/did this child currently have or previously have any of the following (check all that apply):

- ☐ IEP (age): _____
- ☐ 504 plan (age): _____
- ☐ Tutoring (subject): _____
- ☐ Other accommodations: _____

Easiest subjects: _____ Most difficult subjects: _____

Describe any school problems: _____

_____

_____

IX. Psychiatric/Psychological History

Has this child ever had a neuropsychological or neurodevelopmental evaluation before: Yes / No
date: _____ and findings: _____

Please check the box next to any current or previous conditions:

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Panic disorder
- ☐ Obsessive-Compulsive disorder (OCD)
- ☐ Eating disorder (anorexia or bulimia)

- ☐ Schizophrenia or other "thought disorder"

Treatment. Please check all that apply. Is this child currently or has this child ever been treated by:

- ☐ Psychologist
- ☐ Psychiatrist
- ☐ Counselor
- ☐ Mental Health Counselor
- ☐ Clinical Social Worker
- ☐ Inpatient Hospitalization
- ☐ Partial day treatment program

Other: _____

VII. Family History

People living in the household with the child**:** _____

Mother's name: _____
Age: _____ Education: _____ Occupation: _____
Lives with child? ___Yes ____No If not, sees child how often? _____
Medical problems: _____

Father's name: _____
Age: _____ Education: _____ Occupation: _____
Lives with child? ___Yes ____No If not, sees child how often? _____
Medical problems: _____
Is anyone in the family left-handed? If so, please list: _____

Please indicate whether anyone in the IMMEDIATE family (grandparents, parents, and siblings) has had any of the following:

Condition	**Yes / No**	**List Members**
Cardiac (Heart Attack or Heart Failure	Yes / No	
Coronary artery disease or peripheral vascular disease	Yes / No	
Hypertension	Yes / No	
Stroke, TIA, brain hemorrhage	Yes / No	
Brain tumor or brain cancer	Yes / No	
Cancer	Yes / No	
Diabetes	Yes / No	
Liver disease, hepatitis cirrhosis	Yes / No	
Kidney disease	Yes / No	
Thyroid disease or other endocrine (gland) disorders	Yes / No	
Multiple Sclerosis	Yes / No	
Parkinson's disease	Yes / No	
Dementia or Alzheimer's disease	Yes / No	
Seizures or epilepsy	Yes / No	
Fainting or dizzy spells	Yes / No	

Headache or migraine	Yes / No	
Developmental disorders (e.g., ADHD, autism)	Yes / No	
Other medical issues	Yes / No	

Please indicate whether anyone in the IMMEDIATE family (grandparents, parents, and siblings) has had any of the following:

Condition	**Yes / No**	**List Members**
Depression or seasonal affective disorder	Yes / No	
Bipolar (manic-depressive) disorder	Yes / No	
Anxiety, panic disorder, phobia	Yes / No	
Obsessive-compulsive disorder	Yes / No	
Eating disorder (anorexia or bulimia)	Yes / No	
Schizophrenia or other "thought disorder "	Yes / No	
Substance abuse or addiction	Yes / No	
Other psychiatric conditions	Yes / No	

Is there anything else you would like the doctor to know? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you