CREATIVE BEHAVIORAL CONNECTIONS
creating connections to last a lifetime

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Neuropsychological and Developmental History

CLIENT INFORMATION

Name:_____ Today's Date:_____

Date of Birth (Age):_____( ) Handedness: □ Right □ Left □ Ambidextrous

Primary Language:_____ Secondary Language:_____

Grade and School:_____

Special Placement (if any):_____

Who referred you for this evaluation?_____

Name of person completing this questionnaire/ relationship:_____

REFERRAL INFORMATION

Please describe the symptoms or problems that are of most concern to client:_____

_____

_____

When did these problems start?_____

_____

Have they gotten worse over time? Please describe:_____

_____

In your opinion, what are the major causes of the difficulties?_____

_____

Describe client's strengths:_____

_____

Describe some of client's weaker areas:_____

_____

Has the client had a psychological evaluation before? ☐ Yes ☐ No

If yes, by whom:_____ Date:_____

Tests given:_____

_____

Outcomes/Diagnosis:_____

Is this evaluation subject to litigation of any kind? ☐ Yes ☐ No If yes, please explain:_____

FAMILY INFORMATION

Parents:

Mother's name:_____ Age:_____

Highest Education:_____ Occupation:_____

Father's name:_____ Age:_____

Highest Education:_____ Occupation:_____

Parents are: □ married □ separated □ remarried □ deceased

□ divorced (custody arrangement:_____)

Child is: □ biological □ adopted (at age:_____) □ foster (since age:_____)

Siblings: (names/age). How does the client get along with them?_____

_____

_____

Others living in the home (names, ages, relationship):_____

_____

Child care arrangements (if needed: what type? Hours/days?)_____

_____

Has the client experienced death or separation from a loved one? Describe:_____

_____

Are there any significant family or marital conflicts? Explain:_____

_____

PREGNANCY AND BIRTH HISTORY

Age of Mother _____ and father _____ at client's delivery.

How many prior pregnancies?_____ How many prior miscarriages?_____ Fertility Specialist consulted?

□ Yes □ No If yes, which procedure:_____

Known health problems of mother during pregnancy: □ Vaginal Bleeding □ Toxemia □ Trauma

□ Hypertension □ Gestational Diabetes □ Fever/Rash □ Blood incompatibility □ Injury

□ Other:_____

Did mother use tobacco during pregnancy? □ Yes □ No If yes, how often?_____

Was there tobacco use in the home?_____

Did mother drink alcohol during pregnancy? □ Yes □ No If yes, how often?_____

Did mother use illegal substances during pregnancy? □ Yes □ No If yes, please describe (what substance, how much, how often):_____

List any medications used during pregnancy and frequency:_____

_____

Delivery was: □ Vaginal □ Cesarean (reason_____)

Labor was: □ Spontaneous □ Induced □ Easy □ Moderate □ Hard

Baby was: □ Full term □ Premature (_____ weeks gestation)

Birth weight: _____ pounds _____ ounces

Was labor prolonged? □ Yes □ No Length of Labor:_____

Were forceps used during delivery? □ Yes □ No

Any birth complications: □ cord around neck □ meconium staining □ lack of oxygen/blue □ feet first □ jaundice/yellow Describe:_____

Did baby breath spontaneously? □ Yes □ No Oxygen required? □ Yes □ No

Other interventions required? □ Yes □ No If yes, please explain:_____

In intensive care nursery? □ Yes □ No If yes, length of stay: _____

How old was the baby at discharge from the hospital?_____

Medical problems at discharge?_____

_____

List any problems in the first few months of life:_____

_____

Did mother experience any postpartum depression? □ Yes □ No

DEVELOPMENTAL HISTORY

Motor

Age sat alone:_____ crawled:_____ stood alone:_____ walked alone:_____

Was child slow to develop motor skills or awkward compared to siblings/friends (e.g., running, skipping, climbing, riding a bike, playing ball)? □ Yes □ No If yes, please explain:_____

_____

How is the child's handwriting?_____

Was physical or occupational therapy ever recommended? □ Yes □ No Please explain:_____

_____

Any current motor or coordination issues:_____

Speech/Language

Age child spoke first word: _____ put 2-3 words together:_____

Speech delays or problems (e.g., stuttering or articulation problems)? □ Yes □ No If yes, please describe:_____

Was speech therapy ever recommended/pursued? □ Yes □ No If yes, please describe the age and length of therapy:_____

Was the child slow to learn the alphabet? □ Yes □ No

Was the child slow to learn the names of colors? □ Yes □ No

Was the child slow to learn to count? □ Yes □ No

Other languages spoken in the home, besides English:_____

Language child speaks with parents:_____ siblings:_____ friends:_____

Toileting

Age when toilet trained:_____ Did the child ever have: □ problems with bedwetting

□ urine accidents □ soiling/fecal accidents If yes, at what age:_____

Any current problems with toileting?_____

Adaptive

As an infant, to a significant degree, were 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 □ Difficulty nursing

COGNITIVE, EMOTIONAL AND BEHAVIORAL FUNCTIONING

Has the client ever showed the following?	Describe:
☐ Problem solving difficulties	_____
☐ Concentration difficulties	_____
☐ Memory impairment	_____
☐ Sensory issues	_____
☐ Frequent crying	_____
☐ Irritability	_____
☐ Distractibility	_____
☐ Apathy/Lack of interest	_____
☐ Temper tantrums	_____
☐ Mood swings	_____
☐ Aggression	_____
☐ Self-injurious behaviors	_____
☐ Destructive behaviors	_____
☐ Anxiety/tension	_____
☐ Fearfulness	_____
☐ Repetitive behaviors	_____
☐ Repetitive thoughts	_____
☐ Fatigue	_____
☐ Changes in eating or sleeping	_____
☐ Nightmares	_____
☐ Increased suspiciousness	_____
☐ Unusual thoughts	_____
☐ Hallucinations	_____
☐ Daydreaming	_____
☐ Impulsivity	_____
☐ Restlessness/Hyperactivity	_____

☐ Low frustration tolerance _____

☐ Forgetting _____

☐ Suicidal thoughts _____

☐ Personality changes _____

☐ Legal difficulties _____

☐ Tobacco/alcohol use _____

☐ Other substance use _____

How does the client get along well with: Peers:_____

Adults:_____

Does the client have friends?_____ Keep friends?_____ Understand gestures?_____

Understand jokes?_____ Have a good sense of humor?_____ Understand social cues?_____

Have problems with peer pressure?_____ Get taken advantage of by others?_____

How many friends does the client have? How old are their friends?_____

_____

What does the client like to do for fun?_____

_____

What extracurricular activities is the child involved in?_____

_____

MEDICAL HISTORY

Has the client's vision been checked? □ Yes □ No Any problems?_____

Has the client's hearing been checked? □ Yes □ No Any problems?_____

Please list all illnesses/surgeries/hospitalizations (use additional paper if necessary):

Illness/Condition	Dates	Treatment

Has the client ever had a head injury with loss of consciousness or feeling of being "dazed"? □ Yes □ No

Type of head injury	Date	Loss of consciousness	Outcome

Please list all current medications:

Medication	Amount	Reason

Please list any chronic health conditions/ medical issues:_____

_____

Family history:

Is there a history of learning disabilities? □ Yes □ No Please describe:_____

Is there a history of social problems? □ Yes □ No Please describe:_____

Is there a history of neurological illness? □ Yes □ No Please describe:_____

Is there a history of psychiatric disorders? □ Yes □ No Please describe:_____

Is there a history of addiction/gambling? □ Yes □ No Please describe:_____

Does anyone in the family have a problem similar to the client?_____

EDUCATIONAL HISTORY

Does the client have an IEP or 504 Plan: □ Yes □ No Category:_____

Placement: □ regular classroom □ resource support □ self contained classroom □ speech/OT/PT
□ alternative school setting

Any grades repeated: □ Yes □ No If yes, which grade:_____

Any grades skipped: □ Yes □ No If yes, which grade:_____

Teachers report problems in: □ reading □ spelling □ math □ writing □ attention/concentration
□ socialization □ behaviors:_____

Any other academic or school problems? Please explain:_____

_____

Current grades:_____

Have teachers reported problems that are not evident at home? If so, what are they?_____

_____

INTERVENTION HISTORY

Has the client been seen by another agency, psychologist, psychiatrist, or clinic? □ Yes □ No

Please describe:_____

Would you be willing to sign a release? □ Yes □ No

Please add any other comments that you feel are important for us to know:_____

_____

_____

_____

_____

_____

Parent's Signature Date