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:_____

Current Grade:_____ School:_____

Are there any cultural variables needing consideration? □ No □ Yes:_____

Are there any spiritual variables needing consideration? □ No □ Yes:_____

Are there any handicap needs? □ No □ Yes:_____

Who referred you?_____

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? □ No □ Yes, Dates:_____

Psychologist:_____

Tests given:_____

_____

Outcomes/Diagnosis:_____

Are you willing to sign a release? □ No □ Yes

Is this evaluation subject to litigation of any kind? □ No □ Yes:_____

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 arrangements:_____)

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):_____

_____

Childcare 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:_____

_____

Are there any current or previous legal issues in the family? □ No □ Yes:_____

PREGNANCY AND BIRTH HISTORY

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

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

□ No □ 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? □ No □ Yes, how often?_____

Was there tobacco use in the home?_ □ No □ Yes, how often?_____

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

Did mother use illegal substances during pregnancy? □ No □ Yes, (what, 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? □ No □ Yes, how long?_____

Were forceps used during delivery? □ No □ Yes:

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

□ jaundice/yellow Describe:_____

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

Other interventions required? □ No □ Yes, explain:_____

In intensive care nursery? □ No □ 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? □ No □ Yes, interventions?_____

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)? □ No □ Yes, explain?_____

How is the child's handwriting?_____

Was physical or occupational therapy ever recommended? □ No □ Yes, length:_____

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)? □ No □ Yes, describe:_____

_____

Was speech therapy ever recommended/pursued? □ No □ Yes, length:_____

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 Problems?_____

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

Does the child have allergies to food/medications? □ No □ Yes:_____

Adverse reactions:_____

Primary Care Physician:_____Sign a release? □ Yes □ No

Previous and Current health conditions/ medical issues:

Dates	Providers	Treatment/Outcomes

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

Dates	Reasons	Treatment/ Outcomes

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

Family history:

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

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

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

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

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

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

EDUCATIONAL HISTORY

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

Are you willing to provide a copy of the IEP? □ Yes □ No, reason:_____

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

Any grades repeated: □ No □ Yes, which grades/reason:_____

Any grades skipped: □ No □ Yes, which grades/reason:_____

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

Any other academic or school problems? Please explain:_____

_____

Current letter 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 ABA agency, psychologist, psychiatrist, or clinic? □ No □ Yes:

Dates	Providers	Treatment/ Outcomes

Would you be willing to sign a release? □ Yes □ No, reason: _____

Are you engaged with any community supports (Support groups, social services?) □ No □ Yes:_____

_____

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

_____

_____

_____

_____

_____

Parent's Signature Date