

THE NEUROPSYCHOLOGY CONSULTANTS

Neuropsychological Evaluation, Neurobehavioral Management, Forensic Neuropsychology, Clinical Psychology
5835 Six Forks Road, Suite 200, Raleigh, NC 27609

CHILD BACKGROUND INFORMATION: Please answer all of the following questions as honestly as possible. The background questions are to be answered as they apply to the child.

Person Completing Form _____ Today's Date _____

Child's Name _____ Date of Birth _____

Address _____
Street City State Zip

Parents' or Guardians' Name _____

GENERAL INFORMATION:

HOUSEHOLD MAKEUP

Name	Age	Relationship

Child's parents (circle one): Married Unmarried, living together Divorced Widowed Legally Separated

If child shares a room, with whom? _____

Father's Highest Education Completed _____

Mother's Highest Education Completed _____

Father's occupation and place of employment _____

Mother's occupation and place of employment _____

EDUCATION:

What grade is the child currently in? _____ Type of class _____
(LD, EMR, SEM/SED, Regular class, etc.)

What grades did the child receive during the past grading period? _____

Do you know the results of previous standardized testing or psychological testing?

Has he/she repeated any grades? _____ If yes, which grade(s)? _____

MEDICAL/NEUROLOGICAL AND MENTAL HISTORY:

Physician & Phone _____

Past/current medical conditions _____

Past Hospitalizations and/or Surgeries _____

Current Medication _____

Has the child ever had and/or been treated for substance abuse? _____ Yes _____ No

If yes, please describe _____

Has the child ever had and/or been treated for mental health problems? _____ Yes _____ No

Please list any past psychiatric hospitalizations (when, where why, and how long)? _____

If the child has had or still has problems in any of the following areas, please circle item and describe below:

Problem	Describe
Seeing	
Moving Eyes	
Hearing	
Understanding	
Swallowing	
Balance	
Coordination/Clumsiness	
Numbness, Tingling, Buzzing	
Decreased strength or stiffness of one part of body	
Tics or twitching	
Staring spells or trances	
Bed wetting or bladder issues	
Soiling or other bowel issues	

Noticeable loss of change in abilities	
Headaches	

PREGNANCY, BIRTH, AND DEVELOPMENT

If the mother had any illnesses or complications during pregnancy with this child, please describe _____

If the mother used drugs, alcohol, or smoked during pregnancy with this child, please describe _____

Length of Labor _____ Induced or Natural _____

Pain medications used _____ Vaginal or Cesarean _____

Please indicate the approximate age the child first:

Walked without support _____

Spoken in single words _____

Combined two or three words _____

If there were any problems with the child attaining the following developmental tasks, please circle item and describe below:

Problem	Describe
Sucking/feeding as infant	
Whistling	
Riding tricycle/bicycle	
Buttoning clothing	
Tying shoelaces	
Naming colors	
Saying the alphabet	
Skipping	
Kicking, throwing, catching a ball	
Establishing handedness (right or left)	

CURRENT PROBLEMS:

Please describe what you consider the child's main difficulties now, or the problems that you would most like help with: _____

When and how did you first become aware of these problems? _____

Why do you think the child has these problems? _____

If the child has already been evaluated by the school or other professionals, what were the results: _____

What has been done to help the child and how has this worked? _____

What specific questions about the child would you like us to try to answer in our evaluation?

1) _____

2) _____

3) _____

BEHAVIORS, INTERESTS, AND ACCOMPLISHMENTS:

If your child is difficult to manage at home, please describe: _____

If there are other problems, or anything unusual, with regard to the child's behavior at home, at school, or in the neighborhood, please describe: _____

If the child has any difficulty getting along with other children (especially children of the same age) please describe: _____

If there are any special problems completing homework, please describe: _____

What are the child's main strengths, positive personality traits, special interests, or areas of accomplishment? _____

**IF THERE IS OTHER INFORMATION THAT YOU FEEL IS IMPORTANT CONCERNING THE CHILD
PLEASE WRITE IT BELOW:**