Stefani Neuropsychology Services

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History Questionnaire

Patient Information

Child's Name:_____DOB:_____Age:_____
First Middle Last
Address:_____Ph #:_____
School Name:_____Grade:_____
School Address:_____Ph #:_____

Referral Information

Referred by:_____
Reason for Consultation:_____
_____

Parent Information

Mother's Name:_____Ph #:_____
First Middle Last
Address (if different from child's):_____
Occupation:_____Company Name:_____
Company Address:_____
Father's Name: _____Ph #:_____
First Middle Last
Address (if different from child's):_____
Occupation:_____Company Name:_____
Company Address:_____
Legal Relationship to Child:

	Mother	Father
Birth Parent	☐	☐
Adoptive Parent	☐	☐
Step-Parent	☐	☐

Legal Date of Adoption:_____

Pregnancy

List all pregnancies in order, including the patient. If a pregnancy ended in miscarriage, state the month.

Year	Name	Length of Pregnancy (months)	Birth weight	Sex	Complications

What was the mother's health during pregnancy with the patient? Was she nervous and apprehensive; unusually happy; moody; other reactions? Describe below.

_____

_____

Did the mother have any of the following during pregnancy with the patient?

Condition	Dates/Duration	Describe
Anemia		
High Blood Pressure		
Swollen Ankles		
Kidney Disease		
Heart Disease		
German Measles		
Flu		
Other Virus Infections		
Toxemia		
Vomiting		
High Temperatures		
Bleeding		
Spotting		
RH/Other Blood Problems		
Headaches		
Urinary Problems		
Nausea		
Persistent Abdominal Pains		
Persistent Lower Back Pains		
Excessive Fatigue		
Any Accidents/Falls		
Other		

Any chronic illness(es) such as diabetes, kidney infection, thyroid, etc.? Describe below.

_____

_____

Medications taken during pregnancy.

Name	Purpose	Duration

Any hospitalizations during pregnancy? When?_____Why?_____
Treatment:_____
Any threatened miscarriage or early contractions? If so, describe_____

_____

Any other unusual conditions/complications? If so, describe_____

_____

Did the mother feel that the living situation or events in the home were comfortable during this period?
Describe_____
What was the father's attitude toward mother being pregnant? If so, describe_____

_____

Additional Comments:_____

_____

Birth History

Hospital Name:_____
Approximately how long was labor (hours)?_____Was labor difficult or easy? Describe
_____
Was labor induced? If so, why?_____How?_____
Were forceps used? If so, why?_____
Did mother have a Cesarean Section? If so, why?_____
Were any medications given during childbirth? If so, what kind?_____
Why?_____
Was anesthesia used during childbirth? If so, what kind?_____
Why?_____
Was this a multiple birth? If so, how many?_____What part of the body was born first?_____
Any bruises? If so, where?_____Any birthmarks? If so, where?_____
What was the baby's color at birth (normal, blue, yellow, etc.)?_____
If the baby was yellow (jaundiced), did he/she receive:
Oxygen: How long?_____Transfusions: How long?_____Phototherapy (lights): How long?_____
Did the baby have any breathing problems? If so, explain_____
Did the baby breathe spontaneously and easily? If no, explain_____
Was the cord wrapped around the baby's neck?_____Did the baby cry quickly?_____
Was there anything exceptional in the baby's condition such as injury, paralysis, excessive crying, need of oxygen or other medical assistance? If so, explain_____
Was the baby placed in an incubator or special crib? If so, why?_____
How early or late was the birth from the expected deliver date?_____
What was the baby's weight at birth?_____How long after birth was the baby taken home?_____
Any other complications before the baby was taken home?_____
Additional Comments:_____
_____

Developmental History

Was the baby breast-fed, bottle-fed or receive both types of feeding?_____
If combined feeding, at what age was transfer from breast to bottle made?_____
If bottle-fed, were there difficulties in finding a suitable formula? Describe_____
_____
Does the mother recall the baby's response to nursing? Active, eager, had to be encouraged? Describe
_____
Which type of feeding was used? Demand □ Time schedule □
When the baby vomited, was he/she apt to bring up his food in small amounts, or did it come up in large quantities and with force? Describe_____
Did the baby have any difficulty sucking as an infant?_____
Did the baby have any difficulty chewing?_____
Were there times when the baby had frequent spells of colic, constipation, or diarrhea? At what ages?
How was it handled? Explain_____
_____
What attitude or mood did the baby seem to express most of the time? Happy; smiling and laughing; "cuddly"; whine; seemed in pain, sad, "old?" Describe_____
Did the baby fail to grow normally? Describe_____
Did the baby fail to gain weight? Describe_____
Was the baby different in any way from brothers and sisters? Describe_____

Did anyone assist the mother in the care and responsibility of the baby during infancy?_____
Was the baby limp? Describe_____
Was the baby stiff? Describe_____
Did the baby show any unusual trembling? Describe_____
Generally babies vary in regard to the amount of activity they show. Which of the following do you think most closely describe your baby during the first few months of his/her life:

☐ Showed a great deal of activity, such as squirming, wiggling, kicking, and otherwise moving about so that it caused concern or difficulty.

☐ Showed very little physical activity, not even showing any increase in movement, interest or response when hungry or when played with.

☐ Showed vigorous activity when awake and when played with but was equally often observed playing quietly and generally relaxed.

Other. Describe_____
_____
During the baby's first year of life, was there anything (even if it had nothing to do with the baby) that caused unhappiness or anxiety, or placed the mother or father under special strain?_____
_____
Each child has his/her own individual sleeping pattern. Describe some of your child's sleeping habits, such as: Thumb-sucking; rocking; requiring a special toy, blanket or other object._____
_____
Did the baby sleep alone in a room? If not, with whom did he/she share it?_____ At what age?_____For how long a period?_____
Did the baby sleep alone in a bed? If not, with whom did he/she share it?_____
At what age?_____For how long a period?_____
Were there any periods when the child was habitually awake crying and any periods in which he/she had to be held or rocked in order to fall asleep? If so, at what age?_____What else would soothe or quiet the child? Describe_____

Motor Milestones	Age
Age sat alone for a sustained period of time	
Age stood	
Age crawled	
Age took first steps	
Age walked unaided	
Age pedaled a tricycle	
Age rode a bicycle	

Language Milestones	Age
Age spoke first words (dada, mama, bye-bye)	
Age spoke in simple phrases	
Age exhibited good sentence structure	
Age difficulty in learning to talk or speech problems, if any Describe	

Which hand does your child prefer? Right □ Left □ Age established?_____
Does your child switch hands?_____
Were there any attempts to change left-handedness to right-handedness? If so, what attempts were made?_____
Were they made at home, school or both?_____

Has the child ever had any motor coordination difficulties such as confusion in regard to left or right-handedness, frequent falling, awkwardness? If so, describe_____
_____
How does your child perform athletically?_____
_____

Toileting:
How old was the child when toilet training was started?_____What methods were used? (State whether child was placed on a receptacle or "toidy" seat; how frequently; how long was he/she left there; what was done if the child was unsuccessful; whether enemas or suppositories were used; whether he/she cried or struggled.)_____
_____
Were training methods made difficult for any physical reasons, such as constipation, diarrhea, etc.?
_____
At what age was bowel control established?____Were there any relapses and under what circumstances did these occur?_____At what ages?_____
Does the child soil at this time?_____
What training methods were used to teach the child bladder control?_____
At what age did the child stop wetting themselves at night?_____
At what age did the child stop wetting themselves in the daytime?_____
Were there any relapses? If so, at what age?_____
Does the child still wet themselves?_____
What were the child's reactions and attitudes toward toilet training?_____
_____

<u>Medical History</u>

Has your child had meningitis or encephalitis? If so, at what age?_____
Has your child had a head injury? If so, at what age?_____Describe_____
_____
Has your child lost consciousness? If so, why?_____ For how long?_____At what age?_____
Has your child had any significant injuries? If so, what?_____At what age?_____
Has your child ever had high or prolonged fevers? If so, at what age?_____
Did he/she have frequent ear infections? If so, at what age?_____
Does your child have any visual defects? If so, explain_____How long?_____
Does your child have any hearing defects? If so, explain_____How long?_____
Does your child suffer from heart disease? If so, explain_____
Does he/she have asthma?_____List medications_____
Has your child had seizures? If so, age of first seizure_____
Has your child been hospitalized? If so, at what age?_____Why?_____
List any other illnesses or accidents the child has had. State age at which occurred, how long each illness lasted, what treatment was given, and if there were any unusual reactions or after effects.

Illnesses	Length lasted	Age	Treatment given	Reactions

List any operations such as Circumcision, Tonsillectomy, adenoidectomy, etc. State age at which operation occurred, if the child was hospitalized (how long), and if there were any complications such as vomiting, high fever, etc.

Operations	Length in hospital	Age	Complications

What was your child told about the operation beforehand?_____

What reaction did your child show afterwards, that is, fearfulness, temper tantrums, increased shyness?_____

Does your child frequently complain of:

Headaches	Yes □	No □	Nausea	Yes □	No □
Weakness	Yes □	No □	Stomach aches	Yes □	No □
Dizziness	Yes □	No □	Chronic Constipation	Yes □	No □
Other	Yes □	No □	Chronic Diarrhea	Yes □	No □

If so, what?_____

List any medications that your child has taken in the past for more than a month (include dosage given and reason it was taken)_____

_____

Is the child on any medications at the present time? If so, what kind and for what was it prescribed?____

_____

Has your child ever had:

Eye Exam	Yes □	No □	Date_____	Findings_____
Ear Exam	Yes □	No □	Date_____	Findings_____
EEG	Yes □	No □	Date_____	Findings_____

Special Medical Tests

Name	Dates	Findings

Consultation with Medical Specialists

Name	Dates	Findings

Has anyone in the patient's family had any of the following

	Yes	Who?	Explain
Neurological disease			
Seizures (epilepsy)			
Hearing problems			
Visual problems			
Emotional problems			
Mental problems			
Slowness in talking			
Slowness in walking			
Hyperactivity			
Learning problems			
Similar problems to patient			
Does any disease run in the family? What?			

Additional Comments:_____
_____

Behavior and Social History
(People living in home with patient)

Name:_____Relationship:_____Age:_____
Education (years):_____Occupation:_____Health:_____
Handedness:_____School or behavior problems:_____
Name:_____Relationship:_____Age:_____
Education (years):_____Occupation:_____Health:_____
Handedness:_____School or behavior problems:_____
Name:_____Relationship:_____Age:_____
Education (years):_____Occupation:_____Health:_____
Handedness:_____School or behavior problems:_____
Name:_____Relationship:_____Age:_____
Education (years):_____Occupation:_____Health:_____
Handedness:_____School or behavior problems:_____
Name:_____Relationship:_____Age:_____
Education (years):_____Occupation:_____Health:_____
Handedness:_____School or behavior problems:_____

(Siblings of the patient living outside the home)

Name:_____Age:_____Education (years)_____
Address:_____Occupation:_____Health:_____
Handedness:_____School or behavior problems:_____
Name:_____Age:_____Education (years)_____
Address:_____Occupation:_____Health:_____
Handedness:_____School or behavior problems:_____
Name:_____Age:_____Education (years)_____
Address:_____Occupation:_____Health:_____
Handedness:_____School or behavior problems:_____

Have there been or are there currently any significant conflicts:
Between the parents? If so, describe_____
Between the child and the parents? If so, describe_____
Between children? If so, describe_____
Does the child seem to have a closer attachment to one parent than the other? Which one?_____
Were there any changes in his/her attachments and if so, when did they occur?_____
Has the child ever required his/her parents or others to do things for them which they were capable of doing for themselves? If so, describe_____
Has the child ever had any frightening experiences? If so, describe the experience, their age and their reaction_____
Does your child have difficulty getting along with children their own age? If so, describe_____
_____
Does your child have difficulty getting along with adults? If so, describe_____
_____
Currently, does your child prefer playing with children of: Same age □ Older □ Younger □ One or two friends □ Many of them □

Are their friends among his/her own social group, or children the parents did not expect them to choose?_____
How does your child occupy themselves?_____
What methods have you used in disciplining: Spanking □ Withholding of privileges □ Withholding of approval and show of affection □ Other, describe_____
How does the child respond to discipline?_____
Has discipline been frequently necessary?_____
Who ordinarily disciplines the child?_____
Have the parents and/or relatives agreed with each other on methods of discipline and privileges or have there been disagreements?_____
_____
During the early years of the child's life, was either parent frequently away or out of the home? (business trips, hospital, military services)_____
Has the child ever expressed fear of: darkness, dogs, trains, or had frightening dreams? If so, at what age?_____Did these fears cause any special problems?_____
_____
Has the child ever had daydreams, fantasies or imaginary companions? If so, at what age?_____
Daydreams_____
Fantasies_____
Imaginary companions_____
Has the child ever lost any person with whom he/she seemed to have a close relationship, such as father, mother, sibling, grandparents, or others? If so, at what age?_____Who?_____
Describe_____
_____
Has the child ever seemed reluctant, or objected to being left in the care of others?
Describe_____
_____
Did the child have any pre-school or school experiences such as nursery or kindergarten in which separation from home was difficult for them?_____
_____
Has the child had any emotional, adjustment or behavioral problems? If so, describe_____
_____
_____
Has the child ever: Screamed □ Stomped □ Thrown things □ Thrown themselves on the floor □ Hurt others □ Hurt themselves □ Held their breath □ Banged his head on things □ Withdrew □
Describe the physical appearance of the child during these periods._____
_____
Did he/she seem to know what they were doing?_____How early did they occur at first?_____
At what age did the child have them most frequently?_____How often did they occur?_____
At what age did they stop?_____By whom were these handled: By mother □ By father □ By nursemaids □ By others_____
Does your child ever eat paint, paper, etc.? Yes □ No □
Has the child ever had angry outbursts, temper tantrums, or other kinds of behavior which caused you concern? Describe_____
_____
Under what circumstances did they seem to occur most frequently?_____
_____
Check the ones that best describe your child:
Shy □ Immature □ Well-behaved □ Impulsive □ More active than other children □
Clumsy using their hands □ Clumsy in walking □

Does the child or did the child ever have any of the following:
Poor handwriting □ Sleep problems □ Toe walking □ Blank spells □ Falling spells □
Thumb sucking □ Tics or twitching □ Average Intelligence □
Difficulty staying with one activity for a reasonable length of time □

School History

Did the child attend nursery school or a pre-school program? If so, give the age started_____ Describe any problems_____
_____
At what age did the child begin school?____If he/she began later than six, why?_____
_____
Describe any problems_____
Has your child ever been retained in one or more grades? If so, which grades?_____
Why?_____
Is the child in a special education class? If so, what kind?_____
When was the child placed there?_____
Does the child receive any special services in school (resource room, tutoring, remedial reading, speech, etc.)? If so, what services?_____For how long?_____
Have you received any help privately for your child? If so, what sort?_____
By whom?_____When?_____How often?_____
Has your child ever skipped one or more grades? If so, which grades?_____Why?_____
_____
Does your child spend a lot of time studying?_____How much?_____
Briefly discuss your child's study habits_____
_____
_____
Circle the word which best describes your child's grades throughout his school experience.

Superior Above average Average Below average Failing

In a few words, describe your child's attitude toward school when he/she first started_____
_____
What is his/her current attitude?_____
Has school reported current problems with:

Reading □ Describe_____
Spelling □ Describe_____
Writing □ Describe_____
Arithmetic □ Describe_____
Behavior □ Describe_____
Social adjustment □ Describe_____
Attention span □ Describe_____
Following directions □ Describe_____

Can you say anything else that might help us understand and help your child?_____
_____
_____

Name of person filling out this form_____
Relationship to child_____Date_____