CNS Child/Adolescent Neuropsychological History Questionnaire

Patient Name: _____ Date: _____

Age: _____ Birth date: _____ Sex: _____ Grade: _____

School attending: _____ Ethnic/ racial background: _____

Primary Language: _____ Secondary Language: _____

Hand used for writing (check one): Right hand: _____ Left Hand: _____

Medical Diagnosis (if any): _____

Mother's name: _____ Father's name: _____

Briefly describe the problem: _____

_____

What specific questions would you like answered by this evaluation?

1. _____

2. _____

3. _____

Symptom Survey

For each symptom your child exhibits, place a check in front of that symptom. Then, check if the symptom is NEW (began within the past year) or OLD (began over a year ago). Add any helpful comments next to the item.

1. Problem Solving

	New	Old
_____ Difficulty planning ahead	_____	_____
_____ Difficulty thinking as quickly as needed	_____	_____
_____ Difficulty doing things in the right order (sequencing)	_____	_____
_____ Difficulty changing a plan or activity when needed	_____	_____
_____ Difficulty completing an activity in a timely manner	_____	_____
_____ Difficulty doing more than one thing at a time	_____	_____
_____ Difficulty completing tasks independently	_____	_____

2. Speech, Language and Math Skills

	New	Old
_____ Difficulty finding the right word to say	_____	_____
_____ Difficulty relaying thoughts in the proper sequence	_____	_____
_____ Difficulty understanding what others are saying	_____	_____
_____ Speech articulation delays	_____	_____
_____ Language use is excessively literal	_____	_____
_____ Difficulty with basic math facts and calculation	_____	_____
_____ Difficulty with math word problems	_____	_____
_____ Difficulty understanding what he/she reads	_____	_____
_____ Reading excessively slowly		

3. Nonverbal Skills

	New	Old
_____ Difficulty telling left from right	_____	_____
_____ Difficulty doing basic motor tasks _	_____	_____
_____ Difficulty reading facial expressions and nonverbal cues	_____	_____
_____ Problems finding his/her way around familiar places	_____	

4. Concentration and Awareness

	New	Old
_____ Highly distractible	_____	_____
_____ Loses train of thought	_____	_____
_____ Problems concentrating in school or doing homework	_____	_____
_____ Seems confused, disoriented or “in a fog”	_____	_____
_____ Difficulty completing lengthy tasks	_____	_____
_____ Other focus or awareness issues (specify)	_____	_____

5. Memory

		New	Old
_____	Forgetting where he/she leaves things	_____	_____
_____	Forgetting school material that was learned previously	_____	_____
_____	Forgetting items needed for backpack or sports	_____	_____
_____	Excessively asks for repetition or reminders	_____	_____
_____	Forgetting events that happened recently	_____	_____
_____	Relying on notes or reminders to remember	_____	_____
_____	Forgetting facts, but remembering how to do things	_____	_____
_____	Forgetting how to do things, but remembering facts	_____	_____

6. Sensory

		New	Old
_____	Loss of feeling or numbness	_____	_____
_____	Problems seeing	_____	_____
_____	Blurred vision	_____	_____
_____	Hearing Loss (which ear? _____)	_____	_____
_____	Ringing in ears or hearing strange sounds	_____	_____
_____	Taste aversions	_____	_____
_____	Temperature (circle: Sensitivity Insensitivity)	_____	_____
_____	Highly sensitive to:	_____	_____

(check all that apply) _____ texture _____ noise/sounds
_____ light _____ odors/smells

7. Physical

		New	Old
_____	Headaches	_____	_____
_____	Dizziness	_____	_____
_____	Nausea or vomiting	_____	_____
_____	Stomach aches	_____	_____
_____	Incontinence (circle: bladder bowel)	_____	_____
_____	Excessive tiredness	_____	_____

_____	Balance problems	_____	_____
_____	Falling/clumsy	_____	_____
_____	Muscle and/or joint pain	_____	_____

8. Mood

		New	Old
_____	Sadness or depression	_____	_____
_____	Anxiety or nervousness	_____	_____
_____	Stress	_____	_____
_____	Irritability	_____	_____
_____	Sleep problems (__Falling asleep __ Staying asleep:)	_____	_____
_____	Become angry more easily	_____	_____
_____	Euphoria (feeling on top of the world)	_____	_____
_____	More emotional (e.g. crying or upset more easily)	_____	_____
_____	Emotionally flat/"don't care" attitude	_____	_____
_____	Finds previously enjoyable tasks to be non-gratifying	_____	_____
_____	Says life isn't worth living/ wishes was never born	_____	_____
_____	Changes in eating habits (Circle: Increase Decrease)	_____	_____

9. Behavior (**check all that apply within the last 6 months**)

_____	Compliant	_____	Teased
_____	Tests rules/limits	_____	Left Out
_____	Impulsive	_____	Aggressive/Destructive
_____	Impatient	_____	Hyperactive

10. Overall

My child's symptoms have developed: _____ Slowly _____ Quickly

My child's symptoms occur: _____ Occasionally _____ Often

Over the past 6 months my child's symptoms have:

_____Worsened _____ Stayed the same

Birth and Developmental

My child's birth was:

On time (within 2 weeks of due date) _____ Premature _____ Late _____

Were there any problems associated with birth (e.g. oxygen deprivation, unusual birth position, wrapped umbilical cord, etc) or the period immediately following (e.g. need for oxygen, special equipment used, convulsions, illness, etc)?

Yes _____ No _____

If yes, describe: _____

Rate your child's developmental progress by checking one descriptor for each of the following areas:

	Early	Average	Late
Walking	_____	_____	_____
Language	_____	_____	_____
Toilet training	_____	_____	_____

Check any conditions noted in early childhood and elementary school:

_____Attention problems _____Head injury/major falls

_____Muscle tightness or weakness _____Clumsiness

_____Hearing Loss _____ Vision _____Speech problems

_____Developmental delay _____Frequent ear infections

_____ Learning disability _____Hyperactivity

Medical History

Childhood Medical History

Check any conditions below that your child has experienced or been diagnosed with. Add any helpful details (age at diagnosis, treatment provided, etc.) next to the item.

_____Head Injuries/ Concussions _____Epilepsy/Seizures

_____Fevers (104°and above) _____Allergies/Asthma

_____Cancer/tumor _____Cerebral palsy

_____Diabetes _____Meningitis

_____Oxygen deprivation _____ Motor/Vocal tics

_____ Headaches/migraines _____ Chiari malformation

Has your child, had an accident which required a hospital visit? _____ Yes _____ No

If yes, please explain: _____

Has your child ever suffered a serious injury to their head? _____ Yes _____ No

If yes, please explain circumstances and any problems following injury: _____

_____

Family Medical History

Check all that apply for your child's parents and siblings (specify who):

_____ Epilepsy/seizures	_____ Stroke/CVA	_____ Left-handedness
_____ Migraines/headaches	_____ Neurologic disease	_____ Cancer
_____ Learning disability	_____ ADHD	_____ School struggles
_____ Anxiety	_____ Depression	_____ Alcoholism
_____ Parental divorce	_____ Parental remarriage	_____ Other: _____

List your child's current medications (over the counter or prescription) and the dosage

Medication and Dosage

_____

_____

_____

_____

_____

List all hospitalizations and surgeries your child has had

_____

_____

_____

Family History

The following questions deal with your child's **biological** mother, father, brothers and sisters.

Is your child adopted? _____ Yes _____ No If yes, at what age? _____

Mother

Mother's name (include maiden name): _____

Child lives with mother? _____ Yes ____ No See's regularly? _____

Mother's occupation: _____ Education level: _____

Mother's age at time of child's birth: _____

Briefly describe mother's health history: _____

_____

Father

Father's name? _____

Child lives with father? ____ Yes ____No Sees regularly? _____

Father's occupation: _____ Education level: _____

Father's age at time of child's birth: _____

Briefly describe father's health history: _____

_____

Siblings

How many brothers and sisters does your child have? _____

Where is your child in the birth order? _____

Are there any unusual problems (physical, academic, psychological) associated with any of your child's brothers or sisters? _____Yes _____ No

If yes, please describe: _____

_____

Child is being raised by? _____

Child's Educational History

Highest grade completed so far: _____

How would you describe your child's performance as a student?

_____ Above average (A) _____ Average (B-C) _____ Below average (D-F)

Best subject(s): _____ Weakest subject(s): _____

Has your child ever repeated a grade? ____ Yes _____ No What Grade?: _____

Has your child ever skipped a grade? ____ Yes ____ No What Grade?: ____

Has your child been placed in special classes or received any special services?

_____ Yes _____ No If yes, Describe: _____

Type of classes your child takes: ____Standard _____ Honors ___ AP/IB ___SelfContained

Recreation and Social History

Briefly list what types of recreation (sports, games, TV, hobbies, etc.) your child enjoys:

_____

Does your child exercise regularly? _____ Yes _____ No Type: _____

If your child plays sports in school, have they ever have a sport-related head injury?

_____Yes _____No If yes, please describe: _____

Which of the following does your child attend regularly?

_____ Church/youth group _____ Scouts ____ YMCA _____4H

_____ Music lessons _____ CASL _____ Indian Guides/Princesses

About how many close friends does your child have (Circle) : None 1 or 2 3+

How often does your child do things with friends each week (include sports)?

_____ Less than 1 time/week _____ 1 or 2 times/week _____ > 3 times/week

Which of the following apply to your child's peer status? (mark all that apply)

___ Shy ___ Follower ____ Leader ___ Liked ___ Loner ___Peacemaker

___ Would like more friends ___ makes, but doesn't keep friends ___ Bossy

My child gets along best with children who are:____ Younger ____ Older ___ Same age

FORM COMPLETED BY (Please Print: _____

Relation to Child: _____

Thank you for taking the time to carefully complete this questionnaire