

Arrowhead Psychological & Behavioral Sciences, LLC
Pediatric Neuropsychology Intake Questionnaire
Child Data Form

Child's Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Gender (circle one): Male Female

SS#: _____ Religion: _____

Person filling out this form (circle one): Mother Father Stepmother Stepfather

Other (please explain): _____

Parents / Guardians / Family (Please circle Birth, Adoptive, or Foster)

Birth / Adoptive / Foster Mother's Name: _____ Education: _____

Birthdate: _____ Home Phone: _____

Home Mailing Address including zip code: _____

Employer: _____

Occupation: _____ Work Phone: _____

Birth / Adoptive / Foster Father's Name: _____ Education: _____

Birthdate: _____ Home Phone: _____

Home Mailing Address including zip code: _____

Employer: _____

Occupation: _____ Work Phone: _____

Stepmother's Name: _____ Education: _____

Birthdate: _____ Home Phone: _____

Home Mailing Address including zip code: _____

Employer: _____

Occupation: _____ Work Phone: _____

Stepfather's Name: _____ Education: _____

Birthdate: _____ Home Phone: _____

Home Mailing Address including zip code: _____

Employer: _____

Occupation: _____ Work Phone: _____

Other Guardian Name(s): _____ Education: _____

Birthdate: _____ Home Phone: _____

Home Mailing Address including zip code: _____

Employer: _____

Occupation: _____ Work Phone: _____

Relationship to Youth: _____

List all people living in household:

<i>Name</i>	<i>Relationship to Child including biological, foster, adoptive</i>	<i>Age</i>

If any brothers or sisters are living outside the home, list their names, ages, where they are living, and why they are no longer in your home:

Primary language spoken in the home: _____

Other languages spoken in the home: _____

Foster / Adoptive Information

(Please complete this information if the child has ever been adopted or placed in foster care)

What age was the child first placed in foster care? _____

If the child is adopted, what age was the child first adopted? _____

How many different foster care / adoptive placements has the child experienced? _____

What type of placements has the child experienced (e.g., orphanage, foster home, group home, shelter care, kinship home, hospitalization, etc.): _____

If the child was adopted, do they know they were adopted? Yes ____ No ____

Does the child have any contact with biological parents? Yes ____ No ____

If yes, with whom, how often, are the visits supervised, how does the child respond after the visits?

If the child is not yet adopted, is there a plan for this to happen? Yes ____ No ____

If yes, what is the time frame? _____

How has the child adjusted to foster care / adoption? _____

Referral Information

Briefly describe your son or daughter’s current difficulties: _____

How long has this been of concern to you? _____

What seems to help this situation? _____

What seems to make this situation worse? _____

Has the child received evaluation or treatment for the current issue or similar issues? Yes _____ No _____

If yes, when and with whom? _____

Is the child on any medication at this time? Yes _____ No _____

If yes, list medication (s), dosages, and name of professional monitoring your child’s medication:

Who referred you to the Arrowhead Psychological & Behavioral Sciences, LLC

What kind of services are you seeking for your son or daughter (for example, change in school placement, therapy, psychological testing, medication, etc.)? _____

What is important for those involved in testing your child to know about him or her?: _____

Describe the best things about your child: _____

Write about something your child does well: _____

Have there been any major changes within the family life or the child’s living situation that have affected your child’s development (e.g., deaths, moves, divorces, loss of job, etc)? _____ No _____ Yes (describe below)

EVENT	DATE	CHILD’S AGE

If parents are separated or divorced, who has physical custody of child? _____

Who has legal custody? _____

How often does the other parent see child? (check one) _____ N/A

Weekly or more often _____ Once or twice a month _____ Few times a year _____ Never _____

Pregnancy / Developmental History

Length of pregnancy (e.g., full term, 34 weeks, 30 weeks, etc.) _____

Length of delivery (number of hours from initial labor pains to birth): _____

Age of mother at pregnancy: _____

Place of birth: _____

Child’s birth weight: _____

Apgar Scores: 1 minute _____ 5 minutes _____

Did any of the following conditions occur during pregnancy / delivery?

- _____ No _____ Yes Bleeding
- _____ No _____ Yes Toxemia / preeclampsia
- _____ No _____ Yes Rh factor incompatibility
- _____ No _____ Yes Frequent nausea or vomiting
- _____ No _____ Yes Serious illness or injury
- _____ No _____ Yes Took prescription or over the counter medication – If yes, name of medication(s)

- No Yes Took recreational drugs – If yes, name of drug(s) _____

 No Yes Used alcoholic beverage – If yes, approximate number of drinks per week _____
 No Yes Smoked cigarettes – If yes, approximate number of cigarettes per day _____
 No Yes Was given medication to ease labor pains – If yes, name of medication(s) _____

 No Yes Delivery was induced
 No Yes Forceps were used during delivery
 No Yes Had a breech delivery
 No Yes Had a cesarean section delivery – reason _____
 No Yes Other problems – please describe _____

Did any of the following conditions affect your child during delivery or within the first few days after birth?

- No Yes Injured during delivery – If yes, please describe _____

 No Yes Cardiopulmonary distress during delivery
 No Yes Delivered with cord around neck
 No Yes Had trouble breathing following delivery
 No Yes Needed oxygen
 No Yes Turned blue
 No Yes Was jaundiced, turned yellow
 No Yes Had an infection
 No Yes Had seizures
 No Yes Was given medication – If yes, name of medication(s) _____

 No Yes Born with a congenital defect – If yes, please describe _____

 No Yes Was in hospital more than 7 days

Have you ever been told that your child might have developmental problems? No Yes (specify)

At what age did your son or daughter begin to do the following? *Please indicate age.*

_____	Turn over	_____	Walk down stairs
_____	Sit up alone	_____	Use single words (e.g., “mama”, “dada”, “ball”, etc.)
_____	Crawl	_____	Put two or more words together (e.g., “mama up”, etc.)
_____	Stand alone	_____	Bowel trained, day and night
_____	Walk alone	_____	Bladder trained, day and night
_____	Walk up stairs		

Did your child have day time toileting accidents after toilet training? Yes _____ No _____

If yes, at what age? _____

Did bed-wetting occur after toilet training? Yes _____ No _____ If yes, until what age? _____

Did bed-soiling occur after toilet training? Yes _____ No _____ If yes, until what age? _____

Were there any medical reasons for day time accidents, bed-wetting or soiling? Yes _____ No _____

If yes, please describe.

Infant / Toddler Temperament

During the first three years of life, in comparison to other children of the same age, was your child

Difficult to feed	_____ Less Often	_____ About the same	_____ More
Difficult to get to sleep	_____ Less Often	_____ About the same	_____ More
Colicky	_____ Less Often	_____ About the same	_____ More
Difficult to put on a schedule	_____ Less Often	_____ About the same	_____ More
Alert	_____ Less Often	_____ About the same	_____ More
Cheerful	_____ Less Often	_____ About the same	_____ More
Affectionate	_____ Less Often	_____ About the same	_____ More
Sociable	_____ Less Often	_____ About the same	_____ More
Easy to comfort	_____ Less Often	_____ About the same	_____ More
Difficult to keep busy	_____ Less Often	_____ About the same	_____ More
Overactive, in constant motion	_____ Less Often	_____ About the same	_____ More
Very stubborn, challenging	_____ Less Often	_____ About the same	_____ More
Apt to cry excessively	_____ Less Often	_____ About the same	_____ More
Emotionally responsive	_____ Less Often	_____ About the same	_____ More
Easy to discipline	_____ Less Often	_____ About the same	_____ More

Was your child adaptable, easy to please and easy to discipline as an infant and toddler? _____ No _____ Yes

If no, please describe: _____

As an infant and toddler, was your child interested in social contact (eye contact, social smile, showing things, sharing experiences)? _____ No _____ Yes

If no, please describe: _____

As an infant and toddler, describe your child regarding his/her ease of self-regulation (e.g., ability to settle down at night, calm self when emotionally shaken, etc.)? _____

(CONTINUE ON NEXT PAGE)

Child's Medical History

Place a check next to any illness or condition that your son or daughter has had. When you check an item, also note the approximate date (or age) of the illness.

<i>Check if yes</i>	<i>Illness or condition</i>	<i>Date(s) or age(s)</i>	<i>Check if yes</i>	<i>Illness or condition</i>	<i>Date(s) or age(s)</i>
_____	Measles	_____	_____	Dizziness	_____
_____	German measles	_____	_____	Frequent or severe headaches	_____
_____	Mumps	_____	_____	Difficulty concentrating	_____
_____	Chicken Pox	_____	_____	Memory problems	_____
_____	Whooping cough	_____	_____	Extreme tiredness or weakness	_____
_____	Diphtheria	_____	_____	Rheumatic fever	_____
_____	Scarlet fever	_____	_____	Epilepsy	_____
_____	Meningitis	_____	_____	Tuberculosis	_____
_____	Encephalitis	_____	_____	Bone or joint disease	_____
_____	High Fever (over 104)	_____	_____	Gonorrhea or syphilis	_____
_____	Convulsions	_____	_____	Anemia	_____
_____	Allergy	_____	_____	Jaundice/hepatitis	_____
_____	Hay fever	_____	_____	Diabetes	_____
_____	PE Tubes (how many)	_____	_____	Cancer	_____
_____	Broken bones	_____	_____	High blood pressure	_____
_____	Hospitalizations	_____	_____	Heart disease	_____
_____	Operations	_____	_____	Asthma	_____
_____	Ear problems (disease, infection, injury, or impaired hearing)	_____	_____	Bleeding problems	_____
_____	Visual problems	_____	_____	Eczema or hives	_____
_____	Fainting spells	_____	_____	Suicide attempt	_____
_____	Loss of consciousness	_____	_____	Pregnancy	_____
_____	Paralysis	_____	_____	Other _____	_____
_____	Injuries to head	_____			

Please describe the head injury, was there loss of consciousness, did it require sutures, did it result in a concussion, etc.

Please describe other serious illnesses, need for stitches, or operations:

<i>Illness / Operation</i>	<i>Age</i>
_____	_____
_____	_____
_____	_____

Has your son or daughter ever been on long-term medication (more than 6 months)? Yes _____ No _____

If yes, when? _____ What kind? _____

CURRENT MEDICAL:

Please indicate whether your son or daughter has had any of the following problems within the last two years. If yes, describe the severity and how often these problems have occurred.

Respiratory

_____ Frequent colds _____

_____ Chronic cough _____

_____ Asthma _____

_____ Hay fever _____

_____ Sinus condition _____

Cardiovascular

_____ Shortness of breathe dizziness with physical exertion _____

_____ Activity limitation due to heart condition _____

_____ Heart murmur _____

Gastrointestinal

_____ Excessive vomiting _____

_____ Frequent diarrhea _____

_____ Constipation _____

_____ Stomach pain _____

Musculoskeletal

_____ Muscle pain _____

_____ Clumsy walking _____

_____ Poor posture _____

_____ Other muscle problems: Describe _____

Neurological

_____ Seizures/convulsions _____

_____ Speech defects _____

_____ Accident prone _____

_____ Has tics/twitches _____

_____ Rocks back and forth _____

Allergies

_____ Allergy to medicine _____

_____ Allergy to food _____

_____ Other allergies _____

Hearing

_____ Ear infections _____

_____ Hearing problems _____

Date of most recent hearing exam _____ Results: _____

Vision

_____ Vision problems _____

_____ Wears glasses or contacts _____

Date of most recent vision exam _____ Results: _____

Medical Care

Child's physician _____ Telephone _____

Physician's mailing Address _____

How often does your son or daughter see a doctor? _____ Date of last visit _____

Has your son or daughter ever had psychological counseling or therapy? Yes _____ No _____

If yes, counselor's name _____

Counselor's Address _____

Telephone _____

Type of counseling and for what issues _____

When _____

Did you find it helpful? _____ No _____ Yes

Has your son or daughter ever attempted suicide? Yes _____ No _____

If yes, When _____ How _____

Please describe the circumstances that led up to the suicide attempt: _____

Did your son or daughter receive any therapy after this suicide attempt? Yes _____ No _____

Has your son or daughter ever talked about wanting to hurt him or herself? Yes _____ No _____

If yes, When _____

Please describe the circumstances that lead up to the suicide ideation: _____

Did your son or daughter receive any therapy after talking about harming themselves? Yes _____ No _____

Has your son or daughter ever had a neurological exam? Yes _____ No _____

If yes, neurologist's name _____ Date of Exam _____

Neurologist's Address _____

Reason for exam _____

Results of exam _____

Has your son or daughter ever had a psychological or psychiatric evaluation? Yes _____ No _____

If yes, doctor's name _____ Date of Eval _____

Doctor's Address _____

Reason for exam _____

Has your son or daughter ever been hospitalized in a psychiatric facility? Yes _____ No _____

If yes, When? _____ Where? _____

Reason? _____

Please list any and all diagnoses your child has been given (e.g., AD/HD, Learning Disabled, PDD, Tourette's, Bipolar, Depression, Anxiety, Asperger's, Autism, etc.):

Family Medical History

Place a check next to any illness or condition that any member of the extended family has had. When you check an item, please specify family member's relationship to your son or daughter (**please include "M" if the relative is from the mothers side or "P" if the relative is from the father's side: example – M. Aunt would be for the child's aunt from the mother's side of the family**).

<i>Check if yes</i>	<i>Condition</i>	<i>Relationship to youth</i>	<i>Check if yes</i>	<i>Condition</i>	<i>Relationship to youth</i>
_____	Alcoholism	_____	_____	Depression	_____
_____	Cancer	_____	_____	Suicide attempt	_____
_____	Diabetes	_____	_____	Heart trouble	_____
_____	Cystic fibrosis	_____	_____	High blood pressure	_____
_____	Kidney disease	_____	_____	Migraine headaches	_____
_____	Multiple sclerosis	_____	_____	Stroke	_____
_____	Tuberculosis	_____	_____	Alzheimer's disease	_____
_____	Hemophilia	_____	_____	Huntington's chorea	_____
_____	Muscular dystrophy	_____	_____	Parkinson's disease	_____
_____	Sickle-cell anemia	_____	_____	Tay-Sachs disease	_____
_____	Tourette's syndrome	_____	_____	Birth defect	_____
_____	Cerebral palsy	_____	_____	Behavior disorder	_____
_____	Emotional disturbance	_____	_____	Mental illness	_____
_____	Mental retardation	_____	_____	Nervousness/Anxiety	_____
_____	Seizures or epilepsy	_____	_____	Reading problem	_____
_____	Other learning disability	_____	_____	Severe head injury	_____
_____	Substance abuse	_____	_____	Substance addiction	_____
_____	Thought problems	_____	_____	Schizophrenia	_____
_____	Other: Describe _____				

Has anyone in the family ever been in special education services? Yes _____ No _____

If yes, who? _____ What type of services? _____

Has anyone in the family ever completed suicide? Yes _____ No _____

If yes, who? _____ When? _____

Has anyone in the family ever been hospitalized in a psychiatric facility? Yes _____ No _____

If yes, who? _____ When? _____

Has anyone in your family witnessed domestic violence? Yes _____ No _____

If yes, who? _____ When? _____

Please describe the domestic violence: _____

Has your child ever experienced any type of abuse (e.g., physical, emotional, sexual, neglect)? _____ No _____ Yes

If yes, what type(s)? _____

When? _____

Please describe _____

Social and Behavior Checklist

Place a check next to the following categories indicating whether you see this area as a strength or an area of concern for your son or daughter.

Strength / Concern

Strength / Concern

_____	_____	interactions with peers	_____	_____	interactions with brothers and sisters
_____	_____	anger management	_____	_____	interaction with strangers
_____	_____	activity level	_____	_____	attention
_____	_____	persistence	_____	_____	planning activities / projects / tasks
_____	_____	energy level	_____	_____	self-control
_____	_____	problem solving	_____	_____	interaction with authority figures
_____	_____	expressing feelings	_____	_____	discussing fears

Since age 5 has your child ever demonstrated: _____ N/A, my child is not 5 years old yet.

- _____ No _____ Yes Anxiety or Oversensitivity to new experiences
- _____ No _____ Yes Verbal aggression such as profanity, making threats and/or disruptive vocalizations
- _____ No _____ Yes Lack of attentiveness
- _____ No _____ Yes Wandering, running away, roaming
- _____ No _____ Yes Hyperactivity – inability to sit still or restlessness
- _____ No _____ Yes Engages in compulsive rituals

If yes, please describe: _____

- No Yes Inability to make friends
- No Yes Physical aggression such as hitting, biting, pinching, kicking, spitting
- No Yes Constant fighting with siblings or peers
- No Yes Property destruction
- No Yes Extreme withdrawal – social isolation – shyness
- No Yes Sudden weight gain or loss
- No Yes Eating objects which are not meant to be eaten
- No Yes Self-injurious behavior such as head banging, head slapping, hair pulling, cutting
- No Yes Nervous habits such as tics; If yes, please describe: _____

- No Yes Thumbsucking
- No Yes Grinding teeth, clicking teeth

Please explain any yes responses:

Do you have concerns related to your child’s ability to control their temper (i.e., tantrums)? Yes _____ No _____

If yes, please describe your concerns: _____

Educational History

What age did your child start going to school? _____

How did your child react to starting school? _____

School History: (please write in the names of the schools with the approximate dates of attendance)

Pre-school: _____ Dates _____

Kindergarten: _____ Dates _____

Elementary: _____ Dates _____

_____ Dates _____

Middle School: _____ Dates _____

_____ Dates _____

High School: _____ Dates _____

_____ Dates _____

Current School: _____ Current Grade: _____

Current Teacher or other school contact: _____ Phone: _____

Please check what you feel best describes your son / daughter in the following areas:

ATTENDANCE	ABILITY	RELATIONS WITH CLASSMATES	BEHAVIOR
Rarely absent	Above Average	Above Average	Above Average
Sometimes absent	Average	Average	Average
Often absent	Below Average	Below Average	Below Average

Place a check next to the following categories indicating whether you see the area as a strength or an area of concern for your son or daughter.

<i>Strength / Concern</i>	<i>Strength / Concern</i>
_____ _____ Reading	Other subjects (please list below)
_____ _____ Arithmetic	_____ _____
_____ _____ Spelling	_____ _____
_____ _____ Writing	_____ _____
_____ _____ Relationship with teachers	_____ _____

Has your son or daughter received any special education services (e.g., title I, 504 Accommodations, speech/language, adaptive physical education, occupational therapy, classroom aide, etc)? Yes _____ No _____

If yes, what type of service (s)? _____

When did the school last evaluate your child? _____

Has your son or daughter been retained in a grade? Yes _____ No _____

If yes, which grade(s) and why? _____