Dr. Emily
PEDIATRIC NEUROPSYCHOLOGIST

Background Form

General Information

Child's Full Name _____ Child's Nickname _____

Date of Birth _____ Current Age _____

Parent/Guardian Name(s) _____

Home Address _____

Preferred Telephone _____ Okay to leave voicemail? _____

School Name _____ Grade _____

Pediatrician Name _____

Referral

Who suggested that you see me? _____

What are your concerns? _____

How old was your child when you first started having concerns? _____

Birth History

____Yes	____No	Medication taken	Describe _____
____Yes	____No	Bleeding	Describe _____
____Yes	____No	High blood pressure	Describe _____
____Yes	____No	Diabetes	Describe _____
____Yes	____No	Illness/accident	Describe _____
____Yes	____No	Smoking	Describe _____
____Yes	____No	Alcohol use	Describe _____
____Yes	____No	Drug use	Describe _____

Additional Comments? _____

How long was your pregnancy? _____

____Yes ____No Was labor induced? _____

____Yes ____No Did labor last longer than 24 hours? _____

____Yes ____No Caesarean section? If yes, reason _____

Describe any problems with delivery _____

Child's birth weight _____

Apgar scores (if known) _____

Did your baby cry right away? _____

How long was your baby in the hospital? _____

Developmental History

Please include your child's age if known. If not, please indicate if milestone was early/normal/late:

	Age	Early	Normal	Late	Comments
Sat alone	_____	_____	_____	_____	_____
Crawled	_____	_____	_____	_____	_____
Walked	_____	_____	_____	_____	_____
Said first word	_____	_____	_____	_____	_____
Use two word phrases	_____	_____	_____	_____	_____
Hand preference	_____	_____	_____	_____	_____
Toilet trained (day)	_____	_____	_____	_____	_____
Toilet trained (night)	_____	_____	_____	_____	_____

Has your child ever received early intervention (such as Babies Can't Wait)? _____

Has your child received physical, occupational, or speech-language therapy? If so, when?

Medical History

Please indicate if your child has had any of the following by checking yes or no. If yes, please describe.

____Yes	____No	Colic	Describe _____
____Yes	____No	Feeding problems	Describe _____
____Yes	____No	Surgeries	Describe _____
____Yes	____No	Hospitalizations	Describe _____
____Yes	____No	Vision problems	Describe _____
____Yes	____No	Hearing problems	Describe _____
____Yes	____No	Ear infections	Describe _____
____Yes	____No	Seizures	Describe _____
____Yes	____No	Head injury	Describe _____
____Yes	____No	Loss of consciousness	Describe _____
____Yes	____No	Headaches	Describe _____
____Yes	____No	Abdominal pain	Describe _____
____Yes	____No	Meningitis	Describe _____
____Yes	____No	Encephalitis	Describe _____
____Yes	____No	Asthma	Describe _____
____Yes	____No	Allergies	Describe _____
____Yes	____No	Bowel/bladder issues	Describe _____
____Yes	____No	Muscle weakness	Describe _____
____Yes	____No	Other	Describe _____

Additional Comments _____

_____

_____

_____

What medications is your child currently taking?

Name	_____	Dose	_____
Name	_____	Dose	_____
Name	_____	Dose	_____
Name	_____	Dose	_____

What medications has your child taken in the past?

Name _____ Name _____

Name _____ Name _____

Which medical specialists follow your child?

Name _____ Specialty _____

Name _____ Specialty _____

Name _____ Specialty _____

Has your child ever been diagnosed with ADHD or another learning disability? _____

_____

On school nights, when does your child go to bed? _____

What time do they get up in the morning? _____

Does your child seem tired when they wake up? _____

Does your child have trouble falling asleep or staying asleep? _____

Mood

Please describe your child's typical mood. _____

_____

Does your child worry? If so, please describe. _____

Has your child ever been diagnosed with a mood disorder (such as anxiety or depression)? _____

Has your child ever participated in therapy? _____

Academic History

Which hand does your child write with? _____ Right _____ Left _____ Both

Any family history of left handedness? _____

Has your child ever had testing at school or privately? Please describe. _____

_____

Skipped or repeated a grade? If so, which?

What type(s) of classroom is your child in? General Ed. Co-Taught Self-Contained

Small Group Other_____

Does your child do their homework independently?

How far in advance does your child study for a test?

How does your child study? Do you help them?

Anything else that you do to support learning?

Has your child ever received the following? If yes, please describe.

____Yes	____No	IEP	Describe
____Yes	____No	504 plan	Describe
____Yes	____No	Response to intervention	Describe
____Yes	____No	Speech therapy	Describe
____Yes	____No	Physical therapy	Describe
____Yes	____No	Occupational therapy	Describe
____Yes	____No	Behavior plan	Describe
____Yes	____No	Suspension	Describe
____Yes	____No	Expulsion	Describe

Please describe any services your child receives at school:

Family History

Parents are _____ Married _____ Separated _____ Divorced

_____ Living together _____ Mother deceased _____ Father deceased

If separated/divorced:

Who has legal custody?

Who has physical custody?

Who lives at home? _____

Language(s) spoken at home (other than English)? _____

If your child was adopted, please provide any information you have on the birth parents.

Sibling name		Age	
Sibling name		Age	
Sibling name		Age	
Father name		Father age	
Father occupation		Father degree	
Mother name		Mother age	
Mother occupation		Mother degree	

Any family history of:

____Yes	____No	Speech problems	Which family member?	
____Yes	____No	ADHD	Which family member?	
____Yes	____No	Learning disability	Which family member?	
____Yes	____No	Intellectual disability	Which family member?	
____Yes	____No	Behavior problems	Which family member?	
____Yes	____No	Genetic disorder	Which family member?	
____Yes	____No	Seizures	Which family member?	
____Yes	____No	Other medical	Which family member?	
____Yes	____No	Anxiety	Which family member?	
____Yes	____No	Depression	Which family member?	
____Yes	____No	Suicide	Which family member?	
____Yes	____No	Bipolar disorder	Which family member?	
____Yes	____No	Other emotional	Which family member?	
____Yes	____No	Drug/alcohol abuse	Which family member?	

Behavior

Any concerns with:

____Yes	____No	Unusual behaviors/tics	Describe _____
____Yes	____No	Social skills with peers	Describe _____
____Yes	____No	Social skills with adults	Describe _____
____Yes	____No	Conflict with parents	Describe _____

Please describe your child's extracurricular activities: _____

_____

Please describe what your child likes to do in their free time: _____

_____

Does your child have chores? If so, what do they do? _____

_____

Do you help your child get ready for school? _____

Do you help your child clean their room? _____

What are your child's strengths? _____

_____

What else should I know about your child? _____

_____

_____

_____

_____

_____

Thank you