NEUROPSYCHOLOGY INTAKE QUESTIONNAIRE (PARENT)

All questions contained in this questionnaire are strictly confidential and relevant to your current neuropsychological evaluation.

DEMOGRAPHIC HISTORY

Child's Name: ____ Date of Appointment: ____/_____/_______

Gender: ☐ M ☐ F Age:___________ DOB: ____/_____/_______ Handedness: ☐ Right ☐ Left ☐ Ambidextrous

Parents' names:____

Address: ____

Phone: _______________________________________ Email: ____

Pediatrician:___________________________________ Referring doctor (if applicable): _________________________________

Primary reason for today's evaluation: ____

____

ASSESSMENT HISTORY

Previous IQ, Educational, Psychological, or Neuropsychological Testing: ☐ Yes ☐ No	If Yes, Date(s): ____ ***If you have the report, please bring it w/ you to your appointment**

HEALTH HISTORY

Does your child have a history of…	**Approximate date/age**
☐ Recurrent ear infections?	
☐ Seizures?	
☐ Recurrent high fevers?	
☐ Vision or hearing problems?	
☐ Stuttering or other speech problems?	
☐ Concussion/traumatic brain injury?	
☐ Coordination problems?	
☐ Sleep apnea?	
☐ Mood disorder (depression, bipolar disorder)?	
☐ Anxiety disorder (generalized anxiety, PTSD, OCD)?	
☐ Eating disorder?	
☐ Autism spectrum disorder?	
☐ Diagnosed learning disability?	
☐ ADD/ADHD?	

If you checked yes to any of the above, please provide additional details below:

____

____

Other major illnesses or injuries	Approximate date/age

Surgeries or hospitalizations	Approximate date/age

BEHAVIORS

What are your child's strengths? ____

____

Please check any of the following that are applicable to your child

☐ Difficulty adjusting to changes in routine	☐ Unusual eating habits (e.g., binging/purging, pickiness)
☐ Repetitive behaviors	☐ Low self-esteem
☐ Sensitive to lights or noises	☐ Body image issues
☐ Obsessive thoughts	☐ Loss of interest in activities
☐ Hyperactivity/restlessness/fidgetiness	☐ Poor gross or fine motor coordination
☐ Difficulty waiting turn/impatience	☐ Frequently misplaces belongings
☐ Impulsivity	☐ Large or rapid fluctuations in mood
☐ Procrastination/difficulty planning ahead	☐ Anger issues/difficulty controlling temper
☐ Difficulty adjusting to changes in routine/ transitions	☐ Depressed mood/sad
☐ Difficulty making eye contact	☐ Anxious, fearful, nervous
☐ Bullying behaviors	☐ Irritability/easily annoyed by others/reduced frustration tolerance
☐ Deliberately annoys others	☐ Frequent complaints of gastrointestinal distress/stomachaches
☐ Getting bullied by others	☐ Excessive concerns about body/health problems
☐ Defiance/disobedience/does not follow rules	☐ Thoughts most people consider to be strange or bizarre
☐ Difficulty getting along with other children his or her age	☐ Seeing, hearing, smelling, or feeling things that are not there
☐ Difficulty making/keeping friends	☐ Delusions (believing things that are very unlikely to be true)
☐ Extreme shyness	☐ Large or rapid fluctuations in mood
☐ Immature for age	☐ Gives up easily
☐ Breaking objects or destroying property	☐ Difficulty understanding humor
☐ Disorganized	☐ Difficulty multitasking or shifting attention
☐ Interrupts conversations	☐ Easily bored
☐ Other:	

If you checked yes to any of the above, please provide additional details below:

____

____

FAMILY MEDICAL/PSYCHIATRIC HISTORY

Please check all that apply to immediate family members (e.g., grandparents, parents, siblings)

	Which family member(s)	Age/date of diagnosis
☐ Genetic disorders		
☐ Movement disorder/tremor		
☐ ADD/ADHD		
☐ Learning disability		
☐ Developmental delay		
☐ Autism spectrum disorder		
☐ Intellectual disability		
☐ Depression		
☐ Bipolar Disorder		
☐ Anxiety		
☐ Post traumatic stress disorder		
☐ Obsessive compulsive disorder		
☐ Tourette's		
☐ Schizophrenia		
☐ Alcohol abuse		
☐ Drug abuse		

If you checked yes to any of the above, please provide additional details below:

____

____

____

DEVELOPMENTAL HISTORY

City/state of birth: ____

Was your child born prematurely? ☐ Yes ☐ No If yes, gestational age: ____

Were there any complications during pregnancy? ☐ Yes ☐ No If yes, please explain: ____

Was your child exposed to any alcohol, illicit drugs, or prescription drugs in utero? ☐ Yes ☐ No

If yes, please explain: ____

Were there any complications in delivery? ☐ Yes ☐ No If yes, please explain: ____

Was your child late to walk? ☐ Yes ☐ No If yes, please explain: ____

Was your child late to walk? ☐ Yes ☐ No If yes, please explain: ____

What languages does your child speak? ____ First Language: _____________________

If not English:

What language is your child most comfortable with currently? _____________________________ Age first learned English:______________

Language spoken at home:________________________________ Language spoken w/ friends:____________________________

EDUCATION

Current grade: ______________ School (and city):____

Current GPA (if applicable): _____________

Typical grades (please circle): A B C D F

Favorite subjects:______________________________
Most difficult subjects:______________________________
Has your child taken any AP/Honors classes ☐ Yes ☐ No If yes, which ones? ______________________________
____
Scores on any standardized testing (PSAT, SAT, ACT, STAR): ______________________________
How does your child feel about school? ______________________________
Please briefly describe any problems your child has had at school: ______________________________
____
Have teachers ever expressed concerns about your child's behaviors? ☐ Yes ☐ No If yes, what were their concerns? ______________
____

Please check all that apply:		
☐ Makes careless mistakes in schoolwork	☐ Runs out of time on tests	☐ Problems with basic math facts
☐ Slow to complete work	☐ Tires easily when studying	☐ Avoids tasks
☐ Poor time management	☐ Difficulty keeping track of due dates	☐ Number/letter reversals
☐ Turns in assignments late	☐ Loses place when reading	☐ Disorganized
☐ Poor handwriting	☐ Needs to reread information	☐ Difficulty multitasking
☐ Spelling problems	☐ Difficulty understanding what is read	☐ Difficulty shifting attention
☐ Difficulty articulating thoughts (either in speech or writing)		☐ Difficulty following instructions

Any history of:
Special Education/Resource room ☐ Yes ☐ No If yes, which grades? ______________________________
Repeating a grade ☐ Yes ☐ No If yes, which grades?______________________________
IEP/504 Plan/Accommodations ☐ Yes ☐ No Diagnosis: ______________________________
Accommodations provided:______________________________
Tutoring ☐ Yes ☐ No If yes, what subject? ______________________________
Speech and language therapy ☐ Yes ☐ No If yes, which grades? ______________________________
Physical/occupational therapy ☐ Yes ☐ No If yes, which grades? ______________________________

If you checked yes to any of the above, please provide additional details below:
____
____

Social History

Are the child's parents ☐ Married/living together ☐ Separated/divorced/living apart ☐ N/A
If separated/divorced, when?:______________________________
What is the current custody arrangement? ______________________________
Mother's Level of Education: ☐ <9 ☐ 9-12 ☐ 12-16 ☐ >16 Occupation:______________________________
Father's Level of Education: ☐ <9 ☐ 9-12 ☐ 12-16 ☐ >16 Occupation:______________________________
Who lives at home with the child? ______________________________
How does the child get along with his/her parents?______________________________
How does the child get along with other children his/her age?:______________________________
Are there any recent changes or stressful circumstances at home to be aware of?______________________________
____

Siblings:

☐ M ☐ F Age: ______________ Grade:__________________

☐ M ☐ F Age: ______________ Grade:__________________

☐ M ☐ F Age: ______________ Grade:__________________

☐ M ☐ F Age: ______________ Grade:__________________

How does the child get along with his/her siblings?____

Has your child ever held a job or formal volunteer position? ☐ Yes ☐ No

If yes, please describe: ____

Are you aware of any alcohol or drug use? ☐ Yes ☐ No If yes, please explain: ____

____

Is your child able to: (please check all that apply)

☐ Prepare simple meals
☐ Use a smartphone
☐ Do his/her own laundry
☐ Keep track of his/her own belongings
☐ Keep track of his/her own homework assignments and due dates
☐ Manage his/her own schedule (e.g., appointments, meetings, practices)
☐ Make simple purchases at the store
☐ Manage his/her own money (e.g., bank account, allowance, credit card)

SLEEP

How would you rate your child's current sleep quality? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How many hours does your child typically sleep per night? _____	How many hours did your child sleep last night? ___________
What time does your child go to bed on school nights? ___________	On weekends? _______________
What time does your child wake up on school nights? ___________	On weekends? _______________
Does your child snore? ☐ Yes ☐ No	Does your child have nightmares? ☐ Yes ☐ No
Does your child wet the bed? ☐ Yes ☐ No	Does your child have difficulty waking up and getting going in the mornings? ☐ Yes ☐ No
Does your child tire easily? ☐ Yes ☐ No	Does your child wake up during the night? ☐ Yes ☐ No

MEDICATION HISTORY

Has your child ever taken medications for:	Current	Past	Which Medications?	Dates:
Depression (e.g., Prozac, Zoloft)	☐	☐		
Anxiety (e.g., Ativan, Xanax)	☐	☐		
Sleep (e.g., Ambien, Lunesta)	☐	☐		
Chronic pain/headaches (e.g., Vicodin, Neurontin, Pamelor)	☐	☐		
ADD/ADHD (e.g., Adderall, Ritalin)	☐	☐		
Seizures (e.g., Topamax, Keppra)	☐	☐		
Other:	☐	☐		

CURRENT MEDICATIONS

Medication:	Reason:
___	___
___	___
___	___
___	___
___	___
___	___
___	___
___	___
___	___
___	___
___	___