RESET FORM

CHILD NEUROPSYCHOLOGICAL HISTORY

Child's name: _____ Date: _____

Address: _____
Street

_____
City State Zip

Phone Number: _____

Age: _____ Date of Birth: _____ Sex: (Check one) ☐ Male ☐ Female

Ethnic/Racial Background: _____

Primary Language: _____ Secondary Language: _____

Hand used for writing: (Check one) ☐ Right ☐ Left

Reason for Referral:

Medical Diagnosis (if any):

Briefly describe the reason for your visit:

Who referred you for this evaluation?

When did the problem begin?

What specific questions would you like answered?

1 _____

2 _____

3 _____

THIS FORM HAS BEEN COMPLETED BY:

Name: _____

Address: _____

Phone Number: _____

Family Information:

Parents:

Mother's name:

DOB: Country of birth:

Mother's primary language: Education (highest lever completed):

Occupation:

Any history of learning disability, speech delay, or special education services while in school:

Yes ☐ No ☑ If yes, please describe: _____

Father's name:

DOB: Country of birth:

Mother's primary language: Education (highest lever completed):

Occupation:

Any history of learning disability, speech delay, or special education services while in school:

Yes ☐ No ☑ If yes, please describe: _____

Any history of learning disability, speech delay, or special education services while in school:
Yes ☐ No ☑ If yes, please describe: _____

Parents' marital status: _____ Child is adopted at age

Siblings (names, ages)

Have any of the siblings been diagnosed with any condition?:

History of Present Illness:

Briefly explain the circumstances and past events that lead to your child's condition:

Describe your child's strengths:

Describe your child's weaknesses:

SYMPTOM SURVEY

For each symptom that applies to your child, please check in the box. Then, check if this is a NEW symptom (within the past year) or an OLD symptom (over one year). Add any helpful comments next to the item.

PROBLEM SOLVING

Check	New	Old	
	○	○	Difficulty figuring out how to do new things
	○	○	Difficulty planning ahead
	○	○	Difficulty thinking as quickly as needed
	○	○	Difficulty doing things in the right order (sequencing problems)
	○	○	Difficulty completing an activity in a reasonable amount of time
	○	○	Difficulty doing more than one thing at a time
	○	○	Difficulty switching from one activity to another activity
	○	○	Easily frustrated
	○	○	Other problem solving difficulties: _____

If necessary, elaborate about anything above:

SPEECH, LANGUAGE, AND MATH SKILLS

Check	New	Old	
	○	○	Difficulty finding the right word to say
	○	○	Difficulty understanding what others are saying
	○	○	Unable to speak
	○	○	Difficulty staying with one idea
	○	○	Slurred speech
	○	○	Odd or unusual speech sounds
	○	○	Difficulty with math
	○	○	Difficulty understanding what s/he reads
	○	○	Difficulty spelling
	○	○	Other speech, language, or math problems: _____

If necessary, elaborate about anything above:

Has your child ever needed speech and language therapy? ☐ Yes ☐ No

If yes, please explain:

NONVERBAL SKILLS

Check	New	Old	
	○	○	Difficulty telling right from left
	○	○	Difficulty doing things s/he should automatically be able to do (e.g. brushing teeth)
	○	○	Problems drawing or copying
	○	○	Difficulty dressing (not due to physical difficulty)
	○	○	Problems finding way around places s/he's been to before
	○	○	Difficulty recognizing objects or people
	○	○	Unaware of things on one side of his/her body:
	○	○	Decline in musical abilities
	○	○	Not aware of time (e.g. time of day, season, year)
	○	○	Slow reaction time
	○	○	Other nonverbal problems: _____

If necessary, elaborate about anything above:

CONCENTRATION AND AWARENESS

Check	New	Old	
	○	○	Highly distractible
	○	○	Losing train of thought easily
	○	○	Problems concentrating
	○	○	Become easily confused or disoriented
	○	○	Blackout spells (fainting)
	○	○	Mind seems to go blank
	○	○	Strange feelings
	○	○	Not very alert or aware of things
	○	○	Other concentration or awareness problems: _____

If necessary, elaborate about anything above:

MEMORY

Check	New	Old	
	○	○	Forgetting where s/he left things (e.g., homework, school supplies)
	○	○	Forgetting names
	○	○	Forgetting what s/he should be doing
	○	○	Forgetting events that happened quite recently (e.g. last meal)
	○	○	Forgetting events that happened long ago (months or year) (e.g. last birthday)
	○	○	Needing hints to remember
	○	○	Forgetting facts learned in school, but can remember how to do things
	○	○	Forgetting how to do things, but can remember facts
	○	○	Forgetting faces of people s/he knows (when they are not present)
	○	○	Other memory problems: _____

If necessary, elaborate about anything above:

MOTOR AND COORDINATION

Check	New	Old	
	○	○	Motor control problems (using a pencil, key, etc.)
	○	○	Weakness on one side of his/her body
	○	○	Difficulty holding onto things
	○	○	Tremor or shakiness
	○	○	Muscle tics or strange movements
	○	○	Difficulties writing (e.g, poor penmanship)
	○	○	Walking more slowly than others
	○	○	Balance problems
	○	○	Often bumping into things
	○	○	Other motor or coordination problems: _____

If necessary, elaborate about anything above

SENSORY

Check	New	Old	
	○	○	Numbness or loss of feeling
	○	○	Tingling or strange skin sensations
	○	○	Difficulty telling hot from cold
	○	○	Problems seeing on one side
	○	○	Blurred vision
	○	○	Double vision
	○	○	Need to squint or move closer to see clearly
	○	○	Losing hearing
	○	○	Ringing in ears or complaints of hearing strange sounds
	○	○	Difficulty tasting food
	○	○	Difficulty smelling
	○	○	Smelling strange odors
	○	○	Other sensory problems: _____

If necessary, elaborate about anything above:

PHYSICAL

Check	New	Old	
	○	○	Headaches
	○	○	Dizziness
	○	○	Nausea or vomiting
	○	○	Urinary incontinence
	○	○	Loss of bowel control
	○	○	Excessive tiredness
	○	○	Other physical problems: _____

If necessary, elaborate about anything above:

BEHAVIOR

Check all that applies to your child in the past 6 months:

	Rate how severe: Mild	Moderate	Severe
Sadness or depression	○	○	○
Anxiety or nervousness	○	○	○
Irritability	○	○	○
Tantrums	○	○	○
Becomes angry more easily	○	○	○
Poor frustration tolerance	○	○	○
Seems more stressed than usual	○	○	○
Hyperactivity	○	○	○
Oppositional or defiant behaviors	○	○	○
Much more emotional (e.g. cries more easily)	○	○	○
Increased apathy (not caring anymore)	○	○	○
Less inhibited	○	○	○
Difficulty being spontaneous	○	○	○
Unusual fears	○	○	○
Sleeping problems:	○	○	○
Change of weight:	○	○	○
Change in eating habits:	○	○	○
Other recent change in behavior or personality:			

If necessary, elaborate about anything above:

Overall, my child's symptoms have developed:
Symptoms occur:
Over the past 6 months, his/her symptoms have:
In summary, there is:

Allergies: (if any)

Please list all FOOD allergies: _____

Please list all DRUG allergies: _____

Please list any OTHER allergies: _____

Medications:

List all over-the-counter and/or prescription medications your child is currently taking, the dosage, and the reason.

Medication	Dosage	Reason
1		
2		
3		
4		
5		
6		

MEDICAL HISTORY:

Pregnancy and Birth History

Where was your child born? _____

Name of hospital: _____

Age of mother at birth: _____ Age of father at birth: _____

Check all that applied to the mother during the pregnancy:

Accident (describe: _____)
Alcohol use
Cigarette smoking
Drug use (marijuana, speed, cocaine, LSD, etc.)
Illness (toxemia, diabetes, high blood pressure, infection, Rh incompatibility, etc.)
Poor nutrition
Psychological problems
Other problems:

List any medications taken by mother during the pregnancy:

Delivery was ☑ vaginal ☐ Cesarean Baby was ☑ full term ☐ premature Birth weight: _____

Apgar scores, if known _____ In NICU? Yes ☐ No ☐ How Long? _____

Were there any problems associated with your child's birth (e.g. oxygen deprivation, unusual position) or the period immediately afterward (e.g. need for oxygen, special equipment used, convulsions, illness, etc.)?

If yes, please describe:

How long after birth was baby discharged from the hospital?

Were there any medical problems after discharge?

Were there any problems during the first few months?

Did the mother experience postpartum (after birth) depression?

Developmental History

Milestones: Age when your child: crawled _____ walked alone _____
spoke 1st words _____ put 2-3 words together _____
toilet trained _____

Are there any other languages spoken at home? _____

Was physical therapy or occupational therapy ever necessary? ☑ No ☐ Yes If yes, please explain:

How well does your child get along with other children? How many close friends?

Medical Conditions

Check all the conditions that your child has been diagnosed with. Add any helpful details (age at diagnosis, treatment provided, etc.) in the space below.

Allergies
Asthma
Attention problems
Autism/Autism Spectrum
Brain infection or disease
Cancer
Cerebral palsy
Chicken pox
Colds (excessive)
Encephalitis
Fevers (104 F or higher)
High fever with seizures
Head injury
Heart problems
Hearing problems
Hyperactivity
Immune system disease
Juvenile diabetes
Kidney problems
Learning disability
Loss of consciousness
Lung (respiratory) disease
Measles or Mumps (Please circle)
Meningitis
Oxygen deprivation
Poisoning
Pneumonia
Speech problems
Tuberculosis
Vision problems
Other:

Helpful details about the checked conditions (if any):

Any history of recurrent ear infections? Yes ☐ No ☑ If yes, how were they treated (e.g., medication, ear tubes): Date of your child's most recent hearing exam:	Any vision problems? Yes ☐ No ☑ If yes, how were/are they treated (e.g., glasses, contacts): Date of your child's most recent vision exam:

Does your child have epilepsy or a seizure disorder? ☐ Yes ☑ No
If yes, check your diagnosed condition below:

Partial
Simple partial (Jacksonian)
Complex partial (Psychomotor)
Partial evolving into generalized

Generalized
Myoclonic
Clonic
Tonic
Tonic-clonic (Grand mal)
Atonic

Unclassified type

DON'T KNOW WHICH TYPE:
Please describe it:

Describe all of the hospitalizations your child has had:

a)

b)

c)

Has your child ever suffered from a serious head injury? ☐ Yes ☐ No

If yes, please explain the circumstances and any subsequent problems:

Has your child been exposed to excessive amounts of lead (e.g., eating paint chips, living next to high concentrations of automobile exhaust fumes, etc.)? ☐ Yes ☐ No

If yes, please explain: _____

How would you describe your child's overall nutrition?
☐ Excellent ☐ Average ☐ Poor

Check all the medical tests that recently have been done and report any abnormal findings:

	Normal	Abnormal Findings
Angiography		
Blood work		
Brain scan		
CT scan		
EEG		
Lumbar puncture or spinal tap		
Magnetic Resonance Imagine (MRI)		
Neurological office exam		
PET scan		
Physician's office exam		
Skull X-ray		
Ultrasound		
Other testing:		

Identify the physician who is most familiar with your child's recent problems:

Name of physician: _____

Address: _____
Street

_____
City State Zip

Phone: _____

Date of your child's last medical check-up: _____

Findings of last check-up:

Family Medical History

Check all that family members and relatives have been diagnosed with. Add any helpful details (family, member, age at diagnosis, treatment provided, etc.) in the space below.

AIDS, ARC, or HIV+	Drug abuse or addiction	Mental retardation
Allergies	Epilepsy or seizures	Migraines
Arteriosclerosis (artery disease)	Hazardous substance exposure	Multiple sclerosis
Arthritis	Heart disease	Parkinson's disease
Alcoholism	Head injury	Polio
Anxiety	Huntington's disease	Personality disorder
Bipolar illness (manic-depression)	Hypertension	Radiation therapy
Blood disorder	Hypotension	Reading problems
Brain desease or infection	Kedney disease	Schizophrenia
Cancer or chemotherapy	Learning disability	Senility (Dementia)
Cerebral Palsy	Liver disease	Speech/language disorder
Cystic Bibrosis	Lung (respiratory) disease	Special education
Depression	Malnutrition	Stroke
Diabetes	Meningitis	Thyroid disease

Other deseases or disabilities: _____

Helpful details about the checked conditions (if any):

Psychiatric History:

Is your child currently in psychotherapy or under psychiatric care? ☐ Yes ☑ No

Has your child ever been prescribed medications for a mental or nervous condition (e.g. ADHD, behavioral dyscontrol, anti-anxiety medication, anti-depressants)? ☐ Yes ☑ No

Has your child had a prior psychological or neuropsychological evaluation? ☐ Yes ☑ No
If yes, provide the following information:

Name of psychologist: _____

Address: _____
Street

_____
City State Zip

Date of and reason for evaluation: _____

Findings of the evaluation: _____

Educational History:

Current grade: _____

Name of School: _____

Is your child receiving or has ever received special education services? ☐ Yes ☑ No

If yes, please describe:

Do you know your child's IEP classification? _____

What kind of grades does your child receive? ☐ ☑

A & B
B & C
C & D
D & F

Please provide any additional helpful information regarding academic performance history:

His/her best subject(s)? Weakest subject(s)?

Has your child ever been held back a grade? ☐ Yes ☑ No
If yes, what grade(s)? _____ Weakest subject(s)? _____

Did your child attend preschool? ☐ Yes ☑ No

If yes, name of program: _____

Please list in chronological order the names of schools attended starting from kindergarten:

Grade	School	Dates

Briefly list the types of hobbies and/or sports that your child enjoys:

Occupational History: (if applicable)

Does the patient hold any jobs? If yes, please describe type of work and hours worked:

Substance Use: (if applicable)

Does the patient use or has ever used alcohol? Yes ☐ No ☐ Don't Know ☐
Does the patient smoke or has ever smoked? Yes ☐ No ☐ Don't Know ☐
If yes, how much and how often: _____
Does the patient use or has ever used recreational drugs? Yes ☐ No ☐ Don't Know ☐
Please check all the drugs you know of that the patient has used or is using:

	Presently using	Used in past
Amphetamines (e.g.dietpills)	☐	☐
Barbiturates (downers,etc.)	☐	☐
CocaineorCrack	☐	☐
Hallucinogens (LSD,acid,STP,etc.)	☐	☐
Inhalants (glue,nitrous,oxide,etc.)	☐	☐
Marijuana	☐	☐
Opiatenarcotics (heroin,morphine,etc.)	☐	☐
PCP (or“angeldust”)	☐	☐

Please list all other drugs: _____

Is the patient sexually active? ☐ Yes ☐ No ☐ Don't Know

Thank you for taking the time and effort to carefully complete this questionnaire.

Please use the space below to make any additional comments: