PEDIATRIC/YOUNG ADULT HISTORY QUESTIONNAIRE

MONTANA NEUROPSYCHOLOGICAL ASSOCIATES
1622 South Avenue West
Missoula, MT 59801
(406) 543-9700

Date: _____

Person Completing Form: _____ Relationship to Patient: _____

Child's First Name: _____ Child's Last Name: _____

Date of Birth: _____ Age: _____

Gender Assigned at Birth: _____ Male _____ Female

Preferred Gender/Current Identity: _____ Male _____ Female _____ Non-Binary _____ Other

Preferred Pronouns (i.e., he/him; she/her/ they/them): _____

Race:

_____ Caucasian/White _____ African American _____ Native American

_____ Asian _____ Hispanic _____ Other: _____

Handedness:

_____ Right _____ Left _____ Ambidextrous _____ Not yet established

Name of School: _____ Grade: _____

Parent Information

Mother's Name:	Father's Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:

List all medications (prescription medications and over-the-counter medications such as aspirin, cough syrup, etc.) that your child currently takes on a regular basis:

Date Prescribed	Medication	Dose	Prescribed By

List all prescription medications your child has taken in the past:

Medication	Dose	Reason Discontinued

CURRENT CONCERNS

	Yes	No	Date First Noticed
Academic Skills			
Aggression (Physical/Verbal)			
Anxiety/Fears			
Apathy			
Attention			
Cheats			
Daydreams			
Depression/Sadness			
Difficulty Finishing Tasks			
Difficulty with Change in Routine			
Drug/Alcohol Abuse			
Defiance/Oppositional			
Fascinated with Fire			
Fails to Follow Directions			
Family Relationships			
Fine/Gross Motor Skills			
Forgets to do Routine Activities			
Hears Things Others do not Hear			
Hurting Self/Others/Animals			
Hyperactivity			
Intellectual Ability			
Impulsivity			
Irritability/Anger			
Language Skills			
Lethargic			
Loses Things			
Low Self-Esteem			
Lying			
Mood Lability/Mood Swings			
Non-compliant with Adult Requests			
Obsessions			
Organizational Skills			
Passivity			
Repetitive Movements/Sounds			
Sees Things Others do not See			
Self-Stimulatory Behavior			
Sexualized Behaviors			
Social Difficulties			
Stealing			
Stutters			
Tantrums			
Toileting/Soiling			
Trauma Experiences			
Withdrawn			
Other Concerns (specify)			

Has the onset of puberty appeared to cause any difficulties for your child? _____ Yes _____ No

If yes, in what way(s)?

Prioritize and describe the specific problem(s) you would like addressed by the evaluation:

Is your child aware of the problem(s) and your concern(s)? _____ Yes _____ No
If yes, what has he/she said to you about the problem(s)?

What strategies have been implemented to address these issues?

	Yes	No		Yes	No
Verbal Reprimands			Time-out (Isolation)		
Removal of Privileges			Rewards		
Physical Punishment			Acquiescence to Child		
Avoidance of Child			Other:		

Have you talked with your child about this evaluation? _____ Yes _____ No
If yes, what was your child's reaction?

PREVIOUS CONSULTATIONS/EVALUATIONS

Please indicate if you child has ever undergone evaluations for the following:

	Yes	No	Dates	Diagnosis/Results
Hearing				
Vision				
Neurological				
Psychological				
Counseling/Case Management				
Speech/Language				
Educational/School/Academic				
Occupational Therapy				
Physical Therapy				
Other (specify)				

Were any of these evaluations helpful? _____ Yes _____ No
If yes, how so?

FAMILY INFORMATION

Who lives in the household in which the child usually lives?

	Biological Mother		Sisters (names/ages);
	Biological Father		Brothers (names/ages):
	Stepmother		Stepsisters (names/ages):
	Stepfather		Stepbrothers (names/ages):
	Adoptive Mother		Foster Siblings (names/ages):
	Adoptive Father		Aunt/Uncle (names/ages):
	Foster Parent(s)		Significant Other
	Grandparent(s)		Other:

Complete page 4 if your child/the patient is adopted and/or is in a foster/group home. Otherwise continue to page 5.

Birth Parent Information

Birth Mother:	Current Age:
Occupation:	Education (highest grade completed):
Birth Father:	Current Age:
Occupation:	Education (highest grade completed):

Marital Status of Birth Parents:	
_____ Married	_____ Never Married
_____ Divorced (date of divorce):	_____ Separated (date separated):

Adoptive Parent Information

Adoptive Mother:	Current Age:
Occupation:	Education (highest grade completed):
Adoptive Father:	Current Age:
Occupation:	Education (highest grade completed):

Marital Status of Adoptive Parents:	
_____ Married	_____ Never Married
_____ Divorced (date of divorce):	_____ Separated (date separated):

Date of Adoption: Month _____ Year _____
Does your child know he/she is adopted? _____ Yes _____ No
Does your child ask questions about his/her birth parents? _____ Yes _____ No
Please describe the questions your child asks and your response:

If never married, separated or divorced, does the child have contact with both parents (biological or adoptive)? _____ Yes _____ No
Frequency: _____ Mood of Visits: _____

Foster Parent/Group Home Information		
Foster Mother:	Foster Father:	
When was the child placed in your home?	Month	Year
Is the child currently living in a group home?	_____ Yes	_____ No
If yes, when was the child placed?	Month	Year
Has the child had previous foster/group home placements?	_____ Yes	_____ No

If yes, please describe:

For what reason was the child placed out of the home for the first time?

When was the last time he/she lived at home? Month _____ Year _____
Does the child have contact with one or both birth parents? _____ Yes _____ No
If yes, please describe the nature and time of these visits:

DEVELOPMENTAL HISTORY INFORMATION

Length of Pregnancy: _____ weeks

Complications during Pregnancy

	Yes	No	Comments
Anemia			
Bleeding			
Alcohol Use			
Drug Use (e.g., Marijuana)			
Heart Disease			
High Blood Pressure			
Hospitalization			
Injury/Accident			
Operation			
Prescribed Medications			
Rh Factor Incompatibility			
Smoked Cigarettes			
Threatened Miscarriage			
Toxemia/Eclampsia			

Labor and Delivery

Please mark any of the following that describe labor and delivery:

	Labor Induced		Delivered by Cesarean Section
	Delivery Aided by Instruments (forceps, vacuum, other)		More than One Baby Born
	Child Blue at Birth		Child Breathed Spontaneously
	Child Bruised at Birth Where on Body:		Child Yellow (Jaundiced) at Birth Treatment:
	Oxygen Administered		Child Placed in Incubator/NICU
List any other delivery/postnatal complications:			

Birth Weight _____ Length of Hospital Stay _____

Apgar Score 1 minute _____ 5 minutes _____

Neonatal Period

Mark any of the following that describe the neonatal period of development:

	Apnea (child stopped breathing)		Colic
	Congenital Anomalies (physical abnormalities child was born with)		Infections
	Sleep Difficulties (sleep walking, falling asleep, sustaining sleep)		Seizures
	Sucking, Swallowing or Chewing Difficulties		Lack of Responsiveness
	Floppy, Tense or Unusual in how Held Body		Difficult to Sooth
	Failure to Thrive/Feeding Failure		Postpartum Depression in Mother
	Other		

Early Developmental Milestones

Indicate your child's approximate age <u>in months</u> for the following milestones:

Sat Alone without Support		Crawl	
Walked without Support		Said Single Words	
Put 2-3 Words Together		Bladder Trained during the Day	
Bowel Trained		Bladder Trained at Night	

Score the following items regarding how your child compared to other children his/her age during the first three years of life:

	Less often than other children	**About the same** as other children	**More often** than other children
Cried			
Had Temper Tantrums			
Showed Fear of New Places and/or Faces			
Seemed Distractible			
Seemed Unresponsive to Discipline			
Engaged in Self Hurting/Injuring Behavior			
Acted Irritable			
Acted Aggressively			
Enjoyed Being Held			
Seemed Overly Active			
Explored Surroundings			
Listened to Stories			
Enjoyed Running and Climbing on Objects			
Enjoyed Playing with Legos and Puzzles			
Showed Emotional Responsiveness			
Demonstrated Coordination			

MEDICAL HISTORY

Indicate if your child has ever been diagnosed and/or had difficulties with any of the following:

	Yes	**No**	**Comments/Information**
Allergies			
Asthma			
Cerebral Palsy			
Diabetes			
Diet/Nutrition			
Eating Difficulties/Eating Disorder			
Frequent Ear Infections			
Ear Tubes Placed (include age)			
Gastrointestinal Problems			
Head Banging			
Head Injury/Concussion			
Headaches/Migraines			
High Fever (104+)			
High Lead Level			
Hospitalization (reason and date)			
Loss of Consciousness			
Meningitis/Encephalitis			
Oxygen Deprivation (Anoxia)			
Physical Complaints			
Seizures			
Self Injurious Behavior			
Sleep Difficulties			
Staring Spells			
Surgeries (provide why and date)			
Tic/Twitching			
Other (specify)			

Ongoing Areas of Child Development

Indicate if there are any concerns regarding your child's abilities in the following areas:

	Yes	No	Comments
Hearing			
Vision			
Gross Motor Coordination			
Fine Motor Coordination			
Speech Articulation			
Difficulty with Textures such as Certain Foods or Clothing (e.g., tags)			

FAMILY HISTORY

Have any blood relatives been diagnosed with any of the following disorders? If yes, indicate family member and whether from the maternal (M) or paternal (P) side of the family:

	Yes	No	M	P	Family Member
ADD/ADHD					
Alzheimer's Disease					
Anxiety Disorder					
Autism/Asperger's Disorder					
Bipolar/Manic Depression					
Cancer					
Chronic Headaches/Migraines					
Depression					
Diabetes					
Drug/Alcohol Abuse					
Epilepsy/Seizures					
Heart Trouble					
High Blood Pressure					
Hyperactivity					
Learning Difficulties (specify)					
Nervous Breakdown					
Obsessive-Compulsive Disorder					
Ocular/Vision Difficulties					
Personality Disorder					
Schizophrenia/Psychosis					
Sleep Disorder/Apnea					
Speech Problems					
Stroke					
Thyroid Problems					
Other (specify)					

SOCIAL/EMOTIONAL HISTORY

Please note any concerns regarding your child's social and emotional history and experiences:

	Yes	No
Does your child get along with other children?		
Does your child get along with adults?		
Does your child have friends?		
Is your child able to keep friends?		
Does your child understand social cues well (when others are angry, sad, etc.)?		
Does your child understand gestures?		
Does your child show empathy?		
Does your child have a good sense of humor?		

Please elaborate on your concerns, if any, regarding your child's social abilities:

Has your child ever experienced or witnessed the following:

	Yes	No		Yes	No
Domestic Violence			Foster Home Placement		
Been Arrested			History of Frequent Moves		
Illness/Death of Family Member or Pet			Legal Concerns		
Natural Disaster, Accident or Serious Injury			Multiple Caregivers		
Parent Separation, Divorce or Re-marriage			Parent Hospitalization(s)		

If yes to any of the above, please elaborate:

If yes to any of the above, does your child experience nightmares, flashbacks, or problems sleeping related to these issues? _____ Yes _____ No

Has your child been the victim of physical, emotional or sexual abuse? _____ Yes _____ No
If yes, was it reported to CPS? _____ Yes _____ No Date: _____
Was the abuse reported to anyone else? _____ Yes _____ No Who? _____

EDUCATIONAL HISTORY

Please list all schools/daycare centers and dates of attendance for your child:

School	Dates	Any Problems?

Briefly summarize your child's current academic grades:

What is/are your child's best academic subject(s)? _____
What is/are your child's most difficult academic subject(s)? _____

Have teachers expressed concerns regarding your child's learning? _____ Yes _____ No
If yes, please explain:

Year	Grade	Subject(s)	Concern

Have teachers expressed concerns regarding your child's behavior? _____ Yes _____ No

If yes, please explain:

Year	Grade	Concern

Have teachers expressed concerns regarding your child's relationships with other children? If yes, please explain: _____ Yes _____ No

Year	Grade	Concern

Has your child repeated any grades? If yes, provide details. _____ Yes _____ No

Year	Grade	Reason

Has your child received any Special Education services? If yes, provide details. _____ Yes _____ No

Year	Grade	Service Type (e.g., Title 1; IEP, 504 Plan; Speech/Language Therapy (SLT); Occupational Therapy (OT); Physical Therapy (PT)

Approximate amount of time mainstreamed _____ minutes

Is truancy a problem for your child? _____ Yes _____ No

Has your child been suspended from school? _____ Yes _____ No

Has your child been expelled from school? _____ Yes _____ No

If yes, please list the number of suspensions/expulsions and reasons:

_____

List your child's strengths and interests:

If there is any other information you would like to convey, please do so here:

Do you wish to speak with the provider alone to discuss any issues regarding your child? _____ Yes _____ No