# *PEDIATRIC/YOUNG ADULT HISTORY QUESTIONNAIRE – Re-Evaluation*

*MONTANA NEUROPSYCHOLOGICAL ASSOCIATES*
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*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): _____

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

| Medication | Dose | Reason Discontinued |
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**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 (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**

Since the previous evaluation, has your child undergone any evaluations, including through the school, and/or have any professionals expressed concern regarding your child's development?

| | 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**

With whom does your child currently live (please list all individuals residing in the home)?

Please describe any changes to your child's family structure since he/she was last seen in our clinic (e.g., divorce, re-marriage of parent, stepsiblings, etc.).

Since the previous evaluation, has your child been placed outside of your home? _____ Yes _____ No
If yes, please explain:

**MEDICAL HISTORY**

Since the previous evaluation, has your child been diagnosed with any new medical conditions, been hospitalized, or had any significant illnesses or injuries? _____ Yes _____ No
If yes, please describe:

**FAMILY HISTORY**

Since the previous evaluation, has there been any new diagnoses of medical and/or psychiatric disorders in any blood relatives? _____ Yes _____ No
If yes, please provide the diagnosis, which family member(s), and whether from maternal (M) or paternal (P) side of the family:

**SOCIAL/EMOTIONAL HISTORY**

Since the previous evaluation, has there been any change in your child's ability to get along with other children or make/keep friends? _____ Yes _____ No
If yes, please describe:

Since the previous evaluation, have you noticed a difference in your child's ability to understand social cues (e.g., know when others are angry or in discomfort), humor, sarcasms, or gestures) OR difficulty showing empathy? _____ Yes _____ No
If yes, please describe:

Since the previous evaluation, have you noticed your child having difficulty with textures such as foods or clothing (e.g., tags)? _____ Yes _____ No
If yes, please describe:

Since the previous evaluation, has your child experienced any traumatic events (e.g., frequent moves, divorce of parents, parent hospitalization, etc.)? _____ Yes _____ No

If yes, please describe the event(s):

Since the previous evaluation, 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**

Since the previous evaluation, has your child changed schools/academic settings? _____ Yes _____ No

If yes, please describe including grade(s), school/academic setting and why the change occurred:

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 subject(s)? _____

Have teachers expressed concerns regarding your child's learning, behavior, or relationships with other children? _____ Yes _____ No

If yes, please explain:

| Year | Grade | Subject(s)/Concern(s) |
|---|---|---|
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Since the previous evaluation, has your child repeated any grades? _____ Yes _____ No

If yes, provide details.

| Year | Grade | Reason |
|---|---|---|
| | | |

Since the previous evaluation, has your child received any Special Education services? _____ Yes _____ No

If yes, provide details.

| Year | Grade | Service Type (e.g., Title 1; IEP, 504 Plan; Speech/Language Therapy (SLT); Occupational Therapy (OT); Physical Therapy (PT) |
|---|---|---|
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Approximate amount of time mainstreamed _____ minutes

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

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

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

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