Confidential Child Neuropsychological History

Confidential history will be placed in a secure location prior to appt. and shredded if appt. not needed. Please attach notes if you need extra room while responding to these questions. Thank you for taking the time to complete this questionnaire in detail as it greatly assists me during my first consultation with you. *PLEASE FILL OUT COMPLETELY- DON'T SKIP SECTIONS.* May indicate N/A if not applicable.

Demographic Data:

Any family members seen previously by Dr. Hagerott? _____

Patient's Name: _____ Prefers to be called: _____ Male / Female

Age:_____ DOB: ____/____/____ Ethnic Background/ Race: _____ Handedness: Right / Left / No Pref

Home Phone (_____)_____ Child lives with: _____

Patient's Address: _____ City/State_____Zip_____

Mother's Name:_____ Father's Name: _____

Date of Birth: _____ Date of Birth: _____

Employer: _____ Employer: _____

Home Address, if different: _____ Home Address, if different: _____

Home Phone: (_____) _____ * Home Phone: (_____) _____*

Work Phone: (_____) _____ * Work Phone: (_____) _____*

Cell Phone: (_____) _____ * Cell Phone: (_____) _____*

Mother's e-mail _____ * Father's e-mail _____*

* Please only furnish numbers which are okay to reach you at and we will assume it is okay to leave a brief message at the numbers you furnish to us.

Important! Which should be the primary number for us to call or leave messages: _____

Referral Information:

Who referred your child for/ suggested an evaluation?:_____

Reason child is being seen:_____

(continue on separate page, if needed)

_____

Developmental History:

Is child adopted? □No □Yes (age at adoption:) If yes, does child know? □No □Yes

Pregnancy/Delivery: Child is number ____ of ___ pregnancies. Number of miscarriages_____ (What trimester?_____)
Mom's age at delivery: ___ Prenatal care? □No □Yes Was mother "high risk" □No □Yes Is child a twin? □No □Yes
Please list complications, illnesses or medical conditions of mother during pregnancy:_____

Pregnancy Medication/ Substance exposure (please also include information regarding use in first trimester prior to mother knowing she was pregnant): □ I'd prefer to discuss in the appointment

Medications mom took during pregnancy: _____
Tobacco use? □ No □ Yes (frequency: Amount per day: ___ or week:____ or month:____ What trimesters? ___)
Alcohol? □ No □ Yes (frequency: Amount per day: ___ or week:____ or month:____ What trimesters? ____)
Other substance use? Type, amount and when used: _____

Birth Weight:___ lb.___oz. Child was:□ Full Term (38-42 wks) □ Early (length of pregnancy in wks: ___) □ Late by __ wks

Labor and Delivery: (Please check all that apply) Hospital of Delivery: _____
□ Induced □ Regular vaginal delivery □ C-Section due to _____ □ Baby in distress □ Meconium in amniotic fluid
□ Difficulty breathing at birth □ Resuscitation required □ Low Apgars (indicate Apgars if known:1 min____ 5 min____)
□ Required special nursery stay (NICU) (length: _____) □ High bilirubin levels (jaundice) level: _____ how treated? _____
□ Discharged home same time as mother □ Mother had health problems during Labor and Delivery Specify type:_____
Medical problems in baby or birth defects noted at birth: _____

Infancy and Preschool Development/ Concerns:

☐ Colicky / Very Fussy	☐ Feeding Problems	☐Sleeping Problems	☐Difficult to comfort as infant
☐ Clumsy	☐ Less sociable	☐ Very active	☐ Difficult to manage

Please consult your child's baby book, if necessary. Please answer as completely as possible or indicate "nml" for normal if you can't remember but are sure this milestone was on time. *Please **do not** leave spaces blank or indicate "late".* At what age did your child:

Hold head up strongly: _____ Smile: _____ Crawl: _____Sit: _____ Walk:_____

Use one word meaningfully: _____ Said 3 or 4 different single words:_____ Put 2 words together: _____

Used sentences: _____ Speech understood by stranger: _____Toilet trained (day): _____ (night): _____

Tied shoes: _____ Pedal a Bike or Trike:_____ Wrote first name: _____ Color "in the lines" _____

If you can not remember or find the baby's development, do you remember development to be early, normal or late?_____

Has your child ever *lost* milestones (skills)? ☐ no ☐ yes If yes, describe_____

Medical History:

Child's Primary Care Doctor: _____ Doctor's phone number: _____

Other doctors your child sees/ has seen: _____

Child's *current* health conditions/ problems: _____

Child's *past* health conditions/ problems: _____

Hospitalizations and Surgeries (indicate reason and year):_____

Has the child ever had the following?: ☐ Seizure ☐ Concussion ☐ Brain Injury ☐ Accidental Poisoning ☐ Loss of oxygen

Hearing: Last Hearing Test date: _____ Results normal? ☐ yes ☐ no Hearing Aides? ☐ no ☐ yes
Vision: Last Vision Test date: _____ Results normal? ☐ yes ☐ no Glasses? ☐ no ☐ Yes for _____
Note: If hearing/ vision have not been screened or you think there is a problem, you should obtain a screening before this testing.

Current medications (name of medications and dosage): _____

Past medications child has taken (except antibiotics): _____

Has the child ever had: ☐ EEG ☐ CT of Brain ☐ MRI of Brain ☐ Genetic Tests ☐ Seen a neurologist
When and results of these tests (may attach if necessary: _____)

Has your child ever received: Speech/ language therapy? ☐ yes ☐ no Beginning when? ____ Now in services? ☐ yes ☐ no
Physical therapy(PT)? ☐ yes ☐ no Beginning when? _____ Now in services? ☐ yes ☐ no
Occupational Therapy (OT)? ☐ yes ☐ no Beginning when? _____ Now in services? ☐ yes ☐ no
Other therapies, such as ABA? (Specify type and when) _____

Psychological History:

Has the child ever seen a: ☐ psychologist ☐ counselor ☐ psychiatrist ☐ none of these
If yes, please indicate name of mental health professional dates of service reason seen and the diagnoses given:

_____ _____ _____
_____ _____ _____

Has the child ever had ☐ psychoeducational testing at school ☐ testing by private psychologist ☐ Neuropsychological eval.
If yes, please describe when and where ***(please send now or bring a copy of report)***:_____

Has anyone ever diagnosed your child with an attentional deficit disorder (ADD or ADHD?) ☐ no ☐ yes When? _____

Other conditions which have been diagnosed by a professional (e.g. depression, anxiety, obsessive compulsive, behavioral disorder?) _____

Educational History For school year 20__/ 20__):

Current grade: _____ Teacher:_____ School: _____ School System (county): _____

Previous schools attended and grades at each: _____ Attended Preschool? □ no □yes Where? _____

Has the child ever: Repeated a grade? □ no □yes (grade_____) Been under a 504 plan? □ no □ yes

Has the child ever received special education (ESE) "IEP"? □ no □ yes Beginning what grade? ___ If yes, please pull out the IEP and only indicate the exceptionalities listed. □ Speech Impaired □ Language Impaired □ OT □ PT
□ Learning Disability □ Gifted □ Intellectual Disability □ Developmentally Delayed (under gr 1) □ Autism
□ Physical or Health Impaired □ Emotional/ Behavior □ Visually Impaired
If you said yes to any of these, please send now or bring copy of IEP to the appt.

Has your child ever been individually tested at school? □ Yes □ No When/results? _____
We absolutely need a copy of all testing. Please send now or bring copy of the school testing to the appt.

Describe any help, other than ESE services described above, child has received (e.g. tutoring, 504): _____

Current grades, academic or behavioral concerns: _____

Please describe any learning problems, academic struggles, conduct or behavioral concerns, weakness in subjects, for ...
Preschool: _____

Kindergarten: _____

Grade 1: _____

Grade 2: _____

Grade 3: _____

Grade 4: _____

Grade 5: _____

Middle School: _____

High School: _____

Family Information: Language(s) spoken in the home: _____

With whom does the child live? □ Mother/ Father □ Mother □ Father □ Guardian □ Grandparent □ Foster care □ _____
□ mother/ step father (his name:) □ father/ stepmother (her name:)
Parents are: □ married (# years_____) □ separated (when?____) □ never married □ divorced
If parents are divorced, age of child at time of separation _____. Who has **legal** custody or is custody shared?_____
What are the visitation/ living arrangements? _____
Parental rights terminated (legally)/ other parent not entitled to medical info? □ no □ yes. If yes, must send court papers

Birth *Father's* highest grade/ degree_____Age now____Occupation: _____ Handed: □right □left
Birth *Mother's* highest grade/ degree_____ Age now____Occupation: _____ Handed: □right □left
Other adults in home(s) child lives in (if child is *adopted , with guardian or stepparent in home,* indicate their information here:)
Name _____ Relation_____ Ed. Level _____ Occupation_____Age _____
Name _____ Relation_____ Ed. Level _____ Occupation_____Age _____

Siblings: (Indicate relationship if not a full biological sibling)

Name:	Age:	DOB:	Sex:	Relation:	Live with patient?	Describe any developmental/ medical/psych/ or educational difficulties, or state "none"

Are there any family circumstances, traumas, deaths of individuals close to the patient, family stressors, etc which are impacting the child at this time or I should be aware of? _____ □ I'd prefer to discuss in the appt

Do you consider discipline/ home behavior to be a problem with this child? □ no □ yes
If "yes", why? _____

Discipline techniques you regularly use with child _____
Which ones have worked best? _____

Does this child get along well with peers and show good social skills? □ no □ yes
If "no", why? _____

Child's interests, hobbies, clubs and extracurricular involvements: _____ __

If your family has a strong religious affiliation, please indicate it here:_____

Family Developmental/Medical/Psychological History: As family history is very important, please consider the child's siblings, parents, grandparents, cousins, aunts and uncles, as far back as you have knowledge of. If undiagnosed, you may indicate that this is a suspected or undiagnosed disorder. Add extra sheets if needed. ***Indicate the relationship to the child***, **not to the parent and add specific diagnoses made.**

History of:	Do any of the child's biological siblings (full or half siblings) have:	Mother and her family: (indicate relation to the child)	Father and his family: (indicate relation to the child)
Epilepsy/ Seizure Disorder	□ N □ Y who? _____	□ N □ Y who? _____	□ N □ Y who? _____
Genetic Disorder	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Muscle, CP, or Neuro-degenerative Disorder	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Tics, Movement Disorders	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Other neurological disorder	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Mental Retardation/ lower IQ	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Placed in special ed. classes	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Learning Disability/ "Dyslexia"	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Speech/ language disorder	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Developmental Delays	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
ADHD/ADD	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Autism/ Aspergers	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Anxiety	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Depression	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Obsessive Compulsive D/O	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Bipolar Disorder	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Psychosis, Schizophrenia	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Behavioral DIsorder	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Sleep Disorder	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Other psychiatric prob/ issue:	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Substance abuse problem	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____
Other med conditions:	□ N □ Y who?___ _____	□ N □ Y who? _____	□ N □ Y who? _____

Name of person completing this questionnaire: _____ Date: _____ Thank you!

Parent Checklist of Records Needed for the Evaluation

This list is a reminder for you so that you can gather the comprehensive records needed for this evaluation. **Please bring COPIES which we may keep** as we will be unable to make copies at the time of the initial appointment and a copying fee will be incurred. You may also prepare and send them in advance (we prefer this mode as sometimes records may be forgotten at the time of the appointment and a second appointment might be necessary to review important evaluations so that the best testing plan is developed for your child). Please send history form and all records by regular US Mail or drop them by our office in person. Do not send them registered/ certified mail as mail delivery sometimes occurs at times when the office is closed and no one is available to sign for them. Do not fax or scan/ email the history form or records so that we have the clearest copy possible.

- □ Child's current or most recent IEP or 504 plan. Bring the full IEP - not just the progress report. We don't need copies of all the child's IEPs but please bring your copies to the appointment in case we need to review them.

- □ All psychological (testing) evaluations done on your child by private psychologists or the school system (including Child Find). Please furnish even if you feel that the findings are no longer valid or are outdated so Dr. Hagerott can understand development and presentation over time.

- □ If the child is receiving OT, PT or Speech/Language therapies, please bring a copy of the most recent evaluation done by the therapist.

- □ Important neurological records (neurological exam report, results of MRI, EEG, genetics, surgical reports, etc.). Your doctor may also fax them to (850) 994-1206.

- □ Hearing (audiological) and vision tests, if impairments are present which can not be corrected with glasses/ hearing aides.

- □ Report card and school work samples, if academic concerns are present. Your teacher may also send to Dr. Hagerott a note of her observations of strengths and weaknesses. If necessary, this may be faxed to (850) 994-1206.

- □ Any other therapy, pediatric, developmental, psychiatric, medical or educational records which are relevant to the evaluation.

- □ If the child is adopted, please furnish any records (orphanage records, adoptions summary, report to the court etc.) describing the child's history and development prior to the child's adoption.

- □ If you are not the biological parent of the child and the child is not in either biological parent's care, you MUST furnish in advance the court records for adoption or guardianship. If the child has not been removed from parent care, a parent must accompany the child to the first appointment. If the child is in foster care, please have the foster care worker also contact our office to determine who needs to sign our consent forms and who should receive copies of the reports.

On the date of the first appointment, you will also need:

- □ Picture ID and your insurance card (if we are filing your insurance)
- □ An up to date list of the child's medications (we will ask for this each time we see the child).
- □ Names and contact information for the doctors you wish for Dr. Hagerott to communicate with.