Child/Adolescent Neuropsychological Questionnaire

Note: If you need more space for any of the answers, please use the back page(s) to elaborate.

Patient Name:_____ Date of Birth:_____
Age:_____ Sex:____ Current grade level:_____Dominant Hand: ◯ R ◯ L ◯ Both/ambi
School: _____ School nurse: _____
Guidance Counselor:_____ Athletic Trainer: _____

Parents/Guardians- please note the questionnaire is framed as if we are directly asking these questions of your child. However, we do anticipate parents completing this questionnaire with/for their child and that adolescents may additionally comment.

Reason for seeking this evaluation:

- ☐ **Concussion**- continue to Section A
- ☐ **Other**- please describe here and then skip to Section B:

Section A: Concussion/Brain Injury History

When was most recent concussion?_____
How did it occur?_____
Did you lose consciousness?_____If yes, for how long?_____
Did you have amnesia for a period of time prior to the injury?_____If yes, for how long?_____
Did you have amnesia for a period of time after the injury? _____If yes, for how long?_____
Were you taken to the hospital?_____Did you have a CT scan?_____An MRI?_____
What were the diagnoses and results of any imaging?_____
How have you been feeling since then- what are your symptoms?

_____

List all other concussions and other (possible) brain injuries (LOC= Loss of consciousness)

Year/Age	Cause	LOC?	Amnesia?	Other symptoms	How long to recover?
		☐	☐		
		☐	☐		
		☐	☐		
		☐	☐		

Section B: Family

Parent (check all that apply: ☐mother ☐father ☐biological ☐adoptive ☐step ☐foster):

Name_____Education:_____Occupation: _____

Parent (check all that apply: ☐mother ☐father ☐biological ☐adoptive ☐step ☐foster):

Name_____Education: _____Occupation: _____

Siblings

Name	Full, half, adoptive, step	Age	Any special needs?

Members of current household or households (including above if they are part of household/s):

_____

Section C: Prenatal/Birth History: Place of Birth_____

Age of mother when you were born: _____Age of father when you were born:_____

	No ✔	Yes ✔	Specifics/Comments
Are you a twin, triplet or other multiple?	☐	☐	
Any problems with this pregnancy?	☐	☐	
Toxin exposure during pregnancy? (e.g., lead, alcohol, nicotine, cocaine, other drugs/substances- specify)	☐	☐	
Any problems during labor and delivery?	☐	☐	
Cesarean (c-section) Delivery?	☐	☐	
Born premature?	☐	☐	
Born late?	☐	☐	

Section D: Infant and PreSchool History

Write in Birth weight: _____	No ✔	Yes ✔	Specifics/Comments
Any problems at birth or as a newborn? APGAR score?	☐	☐	
Cord around neck? Blue? Not breathing? Other birth trauma?	☐	☐	
Required Intensive Care? If yes, how many days?	☐	☐	
Had to stay extra days in hospital? If so, please explain	☐	☐	
Breastfed? If so, for how long?	☐	☐	
Any motor or coordination delays- any PT/OT?	☐	☐	
Any speech delays- any speech therapy?	☐	☐	
Any significant toileting delays- bed-wetting?	☐	☐	
Any social or behavioral difficulties?	☐	☐	

Section E: Other Medical/Health History

Do you have the following or a history of the following? (Check all that apply)	Current ✔	Past history of… ✔	Specifics…
Genetic disorder	☐	☐	
Spina Bifida	☐	☐	
Cerebral Palsy	☐	☐	
Learning Disability	☐	☐	

ADHD/ADD	☐	☐	
Vision problems	☐	☐	
Anemia, hemophilia, other blood disorder	☐	☐	
Malnutrition	☐	☐	
Dietary restrictions/ food intolerances	☐	☐	
Eating disorder	☐	☐	
Speech problems	☐	☐	
Frequent Ear Infections or Hearing problems	☐	☐	
Asthma or other lung/respiratory disorder	☐	☐	
Seizure Disorder	☐	☐	
Fainting/syncope	☐	☐	
Cancer	☐	☐	
Thyroid Disease	☐	☐	
Meningitis or Encephalitis	☐	☐	
Spinal cord injury	☐	☐	
Stroke	☐	☐	
Heart Disease	☐	☐	
Hypertension (high blood pressure)	☐	☐	
Dyslipidemia, High cholesterol	☐	☐	
Liver disease	☐	☐	
Migraines	☐	☐	Frequency: Duration:
Non-migraine Headaches	☐	☐	Frequency: Duration:
Diabetes	☐	☐	
HIV+/ AIDS	☐	☐	
Toxic Exposure (e.g., lead, carbon monoxide)	☐	☐	
Lyme Disease or other insect borne disease	☐	☐	
Arthritis	☐	☐	
Sleep problems/disorders	☐	☐	
Unexplained weight gain or weight loss	☐	☐	
Gastrointestinal disorder	☐	☐	
Depression	☐	☐	
Anxiety, OCD, panic disorder, agoraphobia	☐	☐	
Tourette's or other tic disorder	☐	☐	
Bipolar Disorder "manic depression"	☐	☐	
Schizophrenia or Schizoaffective disorder	☐	☐	
Sexual, Physical and/or Emotional abuse	☐	☐	
Neglect	☐	☐	
Posttraumatic Stress Disorder	☐	☐	
Alcoholism	☐	☐	
Drug abuse or dependence	☐	☐	
Autism or Asperger's	☐	☐	
Mental Retardation/Intellectual Disability	☐	☐	
Neurofibromatosis	☐	☐	
Neuromuscular disease	☐	☐	

Please list allergies: _____

List any/all surgeries with dates: _____

List date and results of any brain/head EEG, CT, MRI, PET, SPECT:

_____

List any genetic testing results:_____

Describe usual pattern of physical activity (gym/PE, sports, other)- (what and how often):

_____

Primary Care Provider: _____

Other Providers involved in care:_____

Substance Use	How often/How much per day	How often/How much per week	✔ if prior problem but not current
Caffeine (coffee, tea, soda, sports drinks)			☐
Alcohol			☐
Marijuana			☐
Nicotine/Tobacco (smoked, chewed, vaped)			☐
Other (e.g., cocaine, opiate misuse, inhalants...)			☐

Family Medical History: Check any conditions experienced by family members and note who on last page:

☐ Dementia ☐ Heart Disease ☐ Cancer (type/s?)

☐ Stroke/TIAs ☐ Alcoholism ☐ Drug Abuse/Dependence

☐ Depression ☐ Anxiety ☐ ADD/ADHD

☐ Learning Disability ☐ Seizure Disorder ☐ Migraines

☐ Other mental illness:_____

☐ Other: Neurologic (e.g., MS, Parkinsons): _____

☐ Other Mental Health:_____

Section F: Educational

Current school:_____

Any Title 1, Head Start or other early intervention programs?_____

History of Special Education? ○ Yes ○ No Which grades?_____

What for?_____Current IEP?_____

History of, or current, 504 plan? ○ Yes ○ No If so, for what?_____

History of OT, PT, or Speech services during school ages? ☐ OT ☐ PT ☐ Speech

When and what for?_____

History of repeating any grades? Which? Why? _____

Does child enjoy school?_____

Does child have friends at school?_____

Have there been problems paying attention, being organized, or getting work done and turned in?

_____

Best Subject/s?_____ Hardest Subject/s?_____

Typical Grades over past several years?_____

If relevant, PSAT or SAT scores_____

How much homework do you have on average each day?_____

Do you play organized sports?_____

Do you belong to clubs or have other organized activities through school, church or another organization?

_____

Section G: Work

What jobs have or do you have?_____

What are your hours currently or usually?_____

Section G: Social

What do you like to do for fun?_____

Are you happy with your friends/social life?_____

How often do you see friends outside of school?_____

Have you been the target of bullying?_____

Please bring a list of all medications and supplements with dosages and frequency to your appointment.

Thank You!

Use this page to expand on your answers if there was not enough room for doing so on the form. Please indicate the question on which you are elaborating.