Neuropsychology Center of Utah

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CHILDHOOD HISTORY FORM

Who Referred you to Neuropsychology Center of Utah: _____

Child's Name: _____

Child's Birth Date : _____

Child's Age: _____

Child's Gender: _____

Child's Grade: _____

Child's Address: _____

Street City State Zip

Briefly state the main concerns you have for your child and how long you have had these concerns:

_____

_____

_____

_____

_____

_____

Child is presently living with (check all that apply):

____ Natural Mother ____ Natural Father ____ Stepmother ____ Stepfather

____ Adoptive Mother ____ Adoptive Father ____ Foster Mother ____ Foster Father

____ Other: _____

Was your child adopted: _____ If so, at what age was your child adopted: _____

Was your child adopted through Foster Care: _____ or a private agency: _____

If your child was adopted, does he/she have contact with birth parents: _____

Does your child know he/she is adopted: _____

Are the child's parent's separated/divorced: _____

If so, how old was your child at the time of separation: _____

Who has primary custody of your child: _____

What is your child's current custody schedule:

_____

PARENT INFORMATION

Mother's Name: _____

Mother's Age: _____

Mother's highest grade completed: _____

Mother's Occupation: _____

Has the mother ever been treated (either with medication or in therapy) for a mental health condition: _____

Has the mother ever had a history of learning disabilities: _____

Does the mother Smoke Tobacco or Vape: _____

Does the mother use Marijuana, in any form (i.e., edibles, oils or smoke): _____

Does the mother excessively use Alcohol: _____

Does the mother regularly take Opioids (i.e., pain medications), Xanax or Ativan: _____

On the mother's side, is there a family history of any Learning, Attention, Behavior or Emotional problems: _____

If Yes, Briefly Describe:

_____

_____

_____

Father's Name: _____

Father's Age: _____

Father's highest grade completed: _____

Father's Occupation: _____

Has the father ever been treated (either with medication or in therapy) for a mental health condition: _____

Has the father ever had a history of learning disabilities: _____

Does the father Smoke Tobacco or Vape: _____

Does the father use Marijuana in any form (i.e., edibles, oils or smoke): _____

Does the father excessively use Alcohol: _____

Does the father regularly take Opioids (i.e., pain medications), Xanax or Ativan: _____

On the father's side, is there a family history of any Learning, Attention, Behavior or Emotional problems: _____

If Yes, Briefly Describe:

_____

_____

_____

Does your child have siblings:

Name	Age	Any Medical, Social, Emotional, or School problems

Are there any stressors in your family you feel are important for NPCU staff to know about? Stressor's could include parental separation, relocation, family finances, etc.:

_____

_____

_____

Has your child ever been Physically, Emotionally or Sexually abused: _____ If so, please describe:

_____

_____

Has your child ever Physically, Emotionally or Sexually abused another person: _____ If so, please explain:

_____

_____

Has your child ever experienced a traumatic event (i.e., exposure to domestic violence, death): _____ If so, please provide a brief explanation:

_____

_____

_____

Has your child ever viewed pornography: _____ If so, at what age did your child first become exposed to pornography: _____ How did your child get access to pornography: _____

Does you child have difficulty refraining from looking at Pornography: _____

PREGNANCY

Were there any complications with the pregnancy: _____ If so, please explain:

_____

_____

At anytime during pregnancy, was your child exposed to Cigarettes, Marijuana, CBD Oil, Opioids, alcohol or any illegal drugs (i.e., Methamphetamines, Cocaine etc.): _____ If so, please explain:

_____

Any medications taken by the mother during pregnancy: _____

Duration of Pregnancy, in weeks: _____

DELIVERY

Type of Labor: Spontaneous: _____ Induced: _____

Type of Delivery: Vaginal: _____ Breech: _____ Caesarean: _____

Any complications during delivery: _____ If so, please explain: _____

_____

Brith weight, in pounds: _____

POST DELIVERY PERIOD

After delivery, did your child experience any complications: _____ If so, please explain: _____

_____

Number of days infant was in the hospital after delivery: _____

INFANCY PERIOD

What was your child like as an infant (age birth to 15 months of age): _____

_____

<u>As an infant, did you child have difficulty with any of the following</u>:

Did not enjoy cuddling: _____ Excessive irritability: _____ Colic: _____ Difficulty Sleeping: _____

Difficulty Nursing: _____ Constantly into things: _____ Was late cooing/babbling: _____

TODDLER

What was your child like as a toddler (age 2-4 years): _____

_____

As a toddler (age 2-4) did your child have difficulty with any of the following:

Excessively active (i.e., climbing on counters or furniture; always on the go): _____

Easily distracted: _____

Would not respond to his/her name when called upon: _____

Had difficulty adapting to change: _____

Was withdrawn and would not interact with family members: _____

Did not engage in imaginary play: _____

Was easily irritable and displayed excessive temper outbursts: _____

Was overly sensitive to clothes, shoes, socks, lights, sounds or textures: _____

Was asked to be removed from either a preschool or daycare setting: _____

Had difficulty maintaining eye contact: _____

MEDICAL HISTORY

Who is your child's pediatrician/primary care physician: _____

Has your child ever experienced any of the following conditions (please mark all that apply):

Diabetes: _____	Irregular Heart Rhythm: _____	Concussion: _____
Seizures: _____	Cancer: _____	Hearing loss: _____
Vision Impairment: _____	Appendicitis: _____	Stroke: _____
Allergies: _____	Chronic Pain: _____	Migraines: _____
Ear Tubes: _____	Adenoids Removed: _____	Tonsillectomy: _____
Fainting: _____	Rash: _____	Influenza: _____
Celiac: _____	Crohnes Disease: _____	Gluten Intolerance: _____

Has your child ever experienced or been diagnosed with a medical condition not listed above: _____ If so, please explain:

_____

Has your child ever had surgery: _____ If so, please explain: _____

_____

Has your child ever been hospitalized in a psychiatric hospital: _____ If so, how many times: _____ when was the last time he/she was hospitalized: _____

Has your child ever seen a mental health counselor:_____

_____

Please list **ALL** medications (including over the counter supplements or oils) your child is **CURRENTLY** taking:

Medication	**Dosage**	**Taken For**	**Who Prescribes**

Please list **ALL** medications (including over the counter supplements or oils) your child has **EVER** taken in the past:

Medication	**Dosage**	**Taken For**	**Who Prescribed**

SLEEP

How well does your child sleep at night: _____

Does your child have difficulty staying asleep: _____

Who does your child prefer to sleep with: _____

Does your child have excessive nightmares: _____

DEVELOPMENTAL MILESTONES

Did your child experience a delay in any of the following (mark all that apply):

Smiling: _____	Sitting: _____	Crawling: _____	Standing: _____
Walking: _____	Cooing: _____	Babbling: _____	Speaking:_____
Articulation: _____	Toileting: _____	Pencil Grip: _____	Cutting: _____
Buttoning: _____	Dressing: _____	Bike Riding: _____	Naming Colors: _____
Identifying Letters: _____	Identifying Shapes: _____	Learning Alphabet: _____	Drawing: _____
Holding a Pencil/Crayon: _____	Eye contact: _____	Reading: _____	Running: _____

COORDINATION

How would you rate your child's fine motor skills:_____

How would you rate your chid's gross motor skills: _____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his or her age? _____

If not, please explain:

_____

_____

How would you rate your child's overall level of intelligence compared to other children?

Below Average: _____ Above Average: _____ Average: _____

SCHOOL HISTORY

What is the name of your child's school: _____

Does your child currently have an Individualized Education Plan (IEP): _____ If your child has an IEP, what is their current classification: _____

If you child doesn't currently have an IEP, have they ever had an IEP: _____

Does your child currently have a 504 Plan: _____ If not, has your child ever had a 504 plan: _____

Has your child ever repeated a grade: _____ If so, which grade: _____

Has your child ever "skipped" a grade: _____ If so, which grade: _____

Does your child meet regularly with a school counselor or school psychologist: _____

Has your child ever been suspended/expelled from school: _____ If so, please explain: _____

_____

In a school setting, has your child ever had or currently has difficulty with (check all that apply):

Excessive tardies: _____	Excessive Absences: _____	Excessive missing assignments: _____
Staying on task: _____	Completing assignments: _____	Talking out excessively: _____
Turning assignments in on time: _____	Organizing classwork: _____	Remembering assignments: _____
Failing grades: _____	Poor citizenship: _____	Arguing with teachers: _____
Aggressive Behavior: _____	Separating from parents: _____	Toileting accidents: _____
Staying in seat: _____	Reversing letters/numbers: _____	Poor handwriting: _____

As best you can recall, please use the following space to provide a brief description of your child's school progress in each grade:

Pre-School: _____

Kindergarten: _____

1st Grade: _____

2nd Grade: _____

3rd Grade: _____

4th Grade: _____

5th Grade: _____

6th Grade: _____

Jr. High: _____

High School: _____

PEER RELATIONSHIPS

Does your child seek friendship with peers: _____

Is your child sought by peers for friendship: _____

Describe briefly any problems your child may have with peers: _____

_____

_____

What does your child enjoy doing with their free time: _____

_____

To your knowledge, has your child ever used Marijuana (in any form), CBD Oils, Alcohol, Opioids or any other illegal drugs: _____ If so, please explain: _____

_____

Has your child ever been in trouble with the police: _____ If so, please explain: _____

_____

Is your child currently on probation: _____

Do you consider your child to have difficulty understanding social cues: _____ If so, please explain: _____

_____

_____

HOME BEHAVIOR

Does your child **OFTEN** display **DIFFICULTY** with any of the following (Check all that apply):

Poor attention to detail: _____
Careless mistakes in schoolwork: _____
Sustaining attention: _____
Listening when spoken to: _____
Finishing tasks: _____
Organizing tasks: _____
Completing schoolwork: _____
Losing things easily: _____
Easily distracted: _____
Forgetful in daily tasks: _____
Fidgety/squirms in seat: _____
Runs or climbs about: _____
On the go, driven like a motor: _____
Talks excessively: _____
Blurts out unexpectedly: _____
Waiting his/her turn: _____
Interrupts intrudes others: _____
Loses temper: _____
Is touchy easily annoyed: _____
Angry and resentful: _____
Argues with authority: _____
Argues with parent(s): _____
Complying with requests: _____
Deliberately annoys others: ___
Blaming others for misbehavior: _____
Conversation skills: _____
Sharing interests: _____
Responding to name: _____
Looking at you when speaking: _____
Maintaining eye contact: _____
Repetitive behaviors: _____
Lining up toys: _____
Inflexible: _____
Problems with change: _____
Insistent on sadness: _____
Fixated on objects: _____
Sensitive to sounds: _____
Sensitive to textures: _____
Sensitive to light: _____
Attached to odd objects: _____
Obsessed with and object: _____
Odd interest: _____
Excessive mood swings: _____
Physically aggressive toward others: _____
Destroys property: _____
Wets the bed: _____
Daytime toileting accidents: _____
Injures animals: _____

INTERESTS AND ACCOMPLISHMENTS

What are your child's main hobbies and interests?

_____

_____

What are your child's areas of greatest accomplishments?

_____

_____

What are your child's strengths?

_____

_____

What do you like most about your child?

_____

_____