SHARED VISION
PSYCHOLOGICAL SERVICES
Building Healthy Connections

THE ASSESSMENT CLINIC
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PEDIATRIC NEUROPSYCHOLOGICAL INTERVIEW

INSTRUCTIONS: To provide a greater understanding of your concerns, please fill in the blanks or check the correct answers. Please answer as thoughtfully and frankly as possible, since this information will provide some direction on how we might address your concerns. All information is regarded as confidential. If you have difficulty with any of the questions, please leave them blank for now. Thank you for taking the time to complete this form.

Name of Child_____ **Date** _____

Date of Birth_____ **Your Relationship to the Child** _____

Home Phone_____ **Cell Phone** _____

Address _____

Parents Divorced or Separated? ☐Yes ☐No

If so, custody arrangement: _____

Sex/Gender:_____ **Handedness:** ☐Left ☐Right

Race/Ethnicity:_____

REFERRAL INFORMATION

Referral Source:_____

Relationship to Child:_____

Address:_____

Phone:_____ **Fax**_____

Reason for Referral

What are your primary concerns (behavior, mood, eating, sleeping, home or school issues, somatic complaints, or relationship issues)?_____

What questions would you like answered?_____

How long have these problems been occurring?_____

In what settings do these struggles normally occur and how do they affect your child's functioning?_____

How do think your child's struggles affect others?_____

Have there been any significant changes or stressors in your child's life during the last year?
☐Yes ☐No if yes, please describe: _____

What are your child's strengths?_____

NEWBORN HISTORY

General Information:

Is your child your biological child or adopted? _____

If adopted, answer the following:

Was the adoption open or closed? _____

Do you have the child's and/or parents' biological background? ☐No ☐Yes

(If so, please explain in the "Notes" section on page 12.)

Where was the child born? (hospital, city, state) _____

Was the child born early by 1 week or more? ☐No ☐Yes If so, how early? _____

Overdue by one week or more? ☐No ☐Yes If so, how overdue? _____

Method of birth: ☐Normal delivery ☐Breech (feet first) ☐Caesarian section

If C-section: ☐Planned ☐Emergency

Pregnancy/Birth Information

Were there any problems or complications during pregnancy or delivery? ☐Yes ☐No

Check any of the following that apply:

☐ Accident	☐ Anemia	☐ Preeclampsia, eclampsia, or toxemia
☐ Bleeding	☐ Diabetes	☐ High blood pressure
☐ Illness	☐ Surgery	☐ Psychological problems or stress
☐ Fetal distress	☐ Excess vomiting	☐ Premature placenta separation

Did the mother take medication or have an X-ray during pregnancy? ☐Yes ☐No

Did the mother drink alcohol during the pregnancy? ☐Yes ☐No

If so, how much: _____ How often: _____

Did the mother use cocaine or any other drugs during pregnancy? ☐Yes ☐No

Did the mother smoke cigarettes during the pregnancy? ☐Yes ☐No

Was labor induced with the child's birth? ☐Yes ☐No

If yes, with what medication(s) was it induced? _____

Was the mother in labor with the child over 24 hours? ☐Yes ☐No

Did the mother's water break more than 24 hours before delivery? ☐Yes ☐No

Did the mother have any postpartum complications? ☐Yes ☐No

Did the mother experience postpartum depression? ☐Yes ☐No

How many pregnancies had this child's mother had? _____

Were there any miscarriages? ☐Yes ☐No How many? _____

Were there any stillbirths? ☐Yes ☐No How many? _____

What was the child's birthweight? _____lbs. _____oz.

How often did the mother see the doctor during her pregnancy with this child? _____

How much time passed before the mother realized she was pregnant? _____

Infancy Information

As an infant, did the child have any of the following problems? Check those that apply.

☐Feeding trouble	☐ Colic	☐Excess vomiting
☐Constipation	☐Blueness (cyanosis)	☐Seizure (convulsions)
☐Need for oxygen	☐Breathing trouble	☐Yellow jaundice
☐High fever	☐Excessive diarrhea	☐Head banging
☐Slow weight gain	☐Stiffness	☐Chronic ear infections
☐Excess irritability	☐Congenital defect	☐Heart disease/defect
☐Hydrocephalus	☐ Bleeding into brain	☐Physical abnormality

Treatment for any of the above: _____

What kind of milk was the child started on? ☐Breast ☐Formula

How old was the child when s/he was weaned from the bottle/breast? _____

At what age did the child first leave the hospital? _____

DEVELOPMENTAL HISTORY

Developmental Milestones

At what age did the child first sit without help?_____
At what age did the child first walk alone?_____
At what age did the child begin to follow simple commands?_____
At what age did the child first use simple sentences?_____
At what age did the child first learn to ride a tricycle?_____
At what age did the child first learn to ride a bicycle? _____

Temperament

Describe the child's early temperament. Check all that apply.

Activity level	❑ Low	❑ Average	❑ High
Sleeping/eating schedule	❑ Predictable	❑ In-between	❑ Unpredictable
Unfamiliar situations	❑ Inhibited/cautious	❑ In-between	❑ Uninhibited
Concentration	❑ Low	❑ Average	❑ High
Social	❑ Very shy, timid	❑ Average	❑ Very friendly
Persistence with activities	❑ Very persistent	❑ Average	❑ Gave up quickly
Sensitivity to sound	❑ Sensitive	❑ Average	❑ Not sensitive at all
Sensitivity to touch	❑ Sensitive	❑ Average	❑ Not sensitive at all
Sensitivity to light	❑ Sensitive	❑ Average	❑ Not sensitive at all
Sensitivity to taste, smell	❑ Sensitive	❑ Average	❑ Not sensitive at all
Intensity	❑ Calm	❑ Average	❑ Emotional
Mood	❑ Happy	❑ Average	❑ Irritable, unhappy
Separation from parents	❑ Sensitive	❑ Average	❑ Not sensitive at all

EDUCATIONAL HISTORY

Preschool/Background

Did the child attend preschool? ☐ Yes ☐ No If yes, at what age?_____
Describe any problems _____
What age did h/she enter 1st grade?_____ If later than six, why?_____
What grade is the child currently in?_____ Current teacher's name:_____
School name and address:_____

Academic Achievement

Please check the item that best describes the child's CURRENT grades:

❑ Superior ❑ Above average ❑ Average ❑ Below average ❑ Failing

Please check the item that best describes the child's grades THROUGHOUT their school experience:

❑ Superior ❑ Above average ❑ Average ❑ Below average ❑ Failing

Has the child repeated any grades? ☐ Yes ☐ No If yes, which grade(s)_____
Has the child skipped any grades? ☐ Yes ☐ No If yes, which grade(s)_____
Most recent ISAT/SAT/ACT scores, as applicable:_____

Has the school reported current problems with the following (check all that apply & describe)?

❑ Reading letters and words:_____
❑ Reading Comprehension:_____
❑ Spelling:_____
❑ Writing:_____
❑ Math (written math, mental calculations, or word problems):_____
❑ Social Studies:_____
❑ Science:_____
❑ Following Directions:_____
❑ Other:_____

Does your child require more time than others to complete his/her school work?

_____

_____

Does your child experience difficulty completing homework? _____

_____

Difficulty with school seemed to begin (age/grade): _____

Testing/Special Services

Has the child ever had educational/psychological testing? ☐Yes* ☐No

If yes, who performed the testing? _____

When was it performed? _____

***Please provide a copy of the results.**

Does the child receive special services at school? ☐Yes ☐No

If yes, please check all that apply and indicate intensity of services:

- ❑ Speech and language
- ❑ Support for learning disability
- ❑ Self-contained classroom
- ❑ Social work
- ❑ Occupational therapy
- ❑ Physical therapy

Previous Diagnoses

Has your child ever been diagnosed with any of the following? Check all that apply:

- ❑ Nonverbal learning disability
- ❑ Receptive or Expressive language Disorder
- ❑ Autism Spectrum Disorder
- ❑ ADHD
- ❑ Pervasive Developmental Disorder
- ❑ Intellectual Disabilities
- ❑ Communication Disorders (Language, Speech, Pragmatics)
- ❑ Specific Learning Disorder (check one): ○Reading ○Writing ○Math
- ❑ Other _____

_____

Who diagnosed your child (name and title) and when?

Name/Title	Date	Diagnosis

MEDICAL HISTORY

Illness

Check any of the following illnesses that the child has had:

- ❑ Measles
- ❑ Mumps
- ❑ Losing consciousness
- ❑ Fainting spells
- ❑ Excess fatigue
- ❑ Ear infections
- ❑ Rheumatoid arthritis
- ❑ Blood in urine
- ❑ Urinary/kidney infections
- ❑ Head injury
- ❑ Poisoning
- ❑ Sleep apnea
- ❑ Whooping cough
- ❑ Pneumonia
- ❑ Asthma
- ❑ Easy bruising
- ❑ Worms (intestinal)
- ❑ Seizures
- ❑ Exposure to TB
- ❑ Chicken pox
- ❑ German measles
- ❑ High blood pressure
- ❑ Blood transfusion
- ❑ Anemia
- ❑ Broken bones
- ❑ Skin problems
- ❑ Binge eating
- ❑ Self-induced vomiting or laxative abuse
- ❑ Nausea/vomiting/diarrhea>72 hours
- ❑ Unintentional weight loss of more than 5 lbs. per month
- ❑ Other serious illness: _____

Types of treatments for any of the above: _____

Medications

Is the child taking any medications? ❑ Yes ❑ No

If yes, please list below:

Name	Dosage	Frequency

Are there noticeable side effects from any of the child's medications? ❑ Yes ❑ No

If yes, please list medication and side effect(s).

Has the child been on previous medications for behavioral reasons? ❑ Yes ❑ No

If yes, please list:

Hospitalizations

Has the child been hospitalized at any time? ❑ Yes ❑ No

If yes, please give the age, year, and reason for hospitalization:

Child's Age	Year	Hospital	Reason

Medical Evaluations

	Date of last evaluation	Results
Physical		
Hearing		
Vision		

BEHAVIORAL/SOCIAL HISTORY

Relationships with Others

Does the child have difficulty getting along with children his/her age? ❑ Yes ❑ No

Does the child have difficulty getting along with adults? ❑ Yes ❑ No

Does the child have a closer relationship with one parent than the other? ❑ Yes ❑ No

Does the child prefer playing with children his/her (check all that apply)

- ❑ Own Age?
- ❑ Older?
- ❑ Younger?
- ❑ One or two friends?
- ❑ Many friends

How does your child get along with others?

Is your child able to maintain friendships and have there been any recent changes in his/her friendships?_____

Extracurricular Activities/Interests

What extracurricular activities is the child involved in? _____

How does the child occupy him/herself in his/her free time? _____

What special interests or talents does the child have? _____

Discipline

What method(s) do you use for discipline?

❑ Spanking ❑ Time-out ❑ Withholding privileges

❑ Time-in ❑ Other (please describe):_____

Who is the primary disciplinarian in the household?_____

How does the child respond to you?_____

Does the child ever have angry outbursts, temper tantrums, or other behaviors that have caused you concern? ☐ Yes ☐ No

If yes, please describe:_____

Under what circumstances do these situations occur?_____

How do you handle these problems?_____

Other

Are you aware of any physical abuse experienced by this child?	☐ Yes	☐ No
Are you aware of any sexual abuse experienced by this child?	☐ Yes	☐ No
Are you aware of any verbal abuse experienced by this child?	☐ Yes	☐ No
Are you aware of any violence witnessed by this child?	☐ Yes	☐ No
Has the child ever been arrested?	☐ Yes	☐ No

Problem Checklist

Check off the problems listed below that apply to the child. Check "New" if this is a new problem (within the past year). Check "Old" if this is a problem that has persisted for longer than one year.

PROBLEM SOLVING

Child has difficulty with the following:	**Old**	**New**
Learning new or complex activities or concepts		
Organizing activities, job work, or personal items at home		
Solving problems a younger child can do		

Understanding explanations		
Benefiting from experiences (makes same errors repeatedly)		
	Old	**New**
Varying play/recreation activities or problem solving strategies		
Switching from one activity to another (transitions)		
Completing an activity in a reasonable amount of time		
Containing frustration (tends to give up easily)		
Other:		

LANGUAGE

Child has difficulty with the following:	**Old**	**New**
Articulation: ❑ Omits sounds ❑ Substitutes sounds ❑ Distorts sounds		
Fluency		
Speaking in a monotone (very little emotion in speech)		
Talking more than average		
Odd or unusual language or vocal sounds		
Understand what others are saying/Comprehension		
Other:		

NONVERBAL SKILLS

Child has difficulty with the following:	**Old**	**New**
Puzzles, blocks, or similar games		
Direction (right/left) or orientation (back/front or up/down)		
Drawing or copying		
Identifying colors ❑ Is color blind		
Recognizing objects or people the child should know		
Dressing (tying shoes, pulling up zipper) not due to physical disability		
Other:		

Child is much better with: ❑ Language than hands-on activities
❑ Hands-on activities than language

ATTENTION

Child has difficulty with the following:	**Old**	**New**
Mind appears to go blank at a time, or loses train of thought		
Difficulty paying attention: ❑ In class ❑ At home ❑ Playing with friends		
Becoming easily distracted		
Other:		

Problems with attention seemed to start around age: _____
Attention problems seem to improve with the following activities: _____

_____

MEMORY AND LEARNING

Child frequently forgets:	**Old**	**New**
Where he/she leaves work assignments or other objects		
What happened recently (e.g. prior meal)		
What happened days or weeks ago		
School assignment		
What she/he has been told recently		

The child can recognize something even if he/she cannot recall it ☐ Yes ☐ No
The child is best at remembering: _____

MOTOR AND COORDINATION

Child has difficulty with the following:	**Old**	**New**
Walking, gait problems ❑Left ❑Right		
Odd movements (posturing, peculiar hand movements, etc.)		
Involuntary or repetitive movements: ❑Eye/facial ❑Vocal ❑Limbs ❑Body		
Oral (mouth) motor problems		
Other motor or coordination problems		

SENSORY

Child has difficulty with the following:	**Old**	**New**
Vision problems ❑Left ❑Right		
Hearing problems ❑Left ❑Right		
Loss of feeling on skin ❑Left ❑Right		
Difficulty smelling or tasting food		
Overly sensitive to: ❑Touch ❑Light ❑Noise		
Other sensory problems:		

BEHAVIORS

Child exhibits the following:	**Old**	**New**
Aggressive to people, animals, or property		
Bizarre or unusual behavior		
Craving or eating of non-food substances		
Dependent for age		
Depressed		
Poor or unusual eating habits		
Emotional		
Fearful or nervous		
Headaches		
Ignores rules		
Immature for age		
Impulsive or disinhibited		
Inappropriate sexual behavior		
Lying		
Low self-esteem		
Nausea		
Nail biting		
Nightmares		
Poor social skills		
Repetitive behaviors		
Risky (dangerous) behaviors		
Stomach aches		
Suicidal acts or statements		
Uninterested in people		
Withdrawn		
Other:		
Other:		

FAMILY HISTORY

Immediate Family

Please complete the following:

RELATIONSHIP	NAME/ AGE	EDUCATION/ OCCUPATION	SPECIAL PROBLEMS	LIVING WITH CLIENT
Parent/guardian (circle role)				☐ Yes ☐ No
Parent/guardian (circle role)				☐ Yes ☐ No
Sibling				☐ Yes ☐ No
Sibling				☐ Yes ☐ No
Sibling				☐ Yes ☐ No
Other/Specify (Biological parent, if adopted)				☐ Yes ☐ No
Other/Specify (2nd biological parent, if adopted)				☐ Yes ☐ No

If parents are married, what year did they marry? _____

If separated or divorced, provide date: _____

Has either parent remarried and/or have additional children? If yes, please describe: _____

Briefly describe the child's relationship with each member of the household: _____

Are there any other individuals who play a significant role in the child's life? _____

Are there any significant family stressors? _____

Please list current support systems and things that are culturally important to your family:

Previously Diagnosed Family Disorders

Please check any of the following conditions that have occurred in the patient's biological family. If diagnoses have been suspected but not diagnosed, please indicate accordingly:

CONDITION	FATHER	MOTHER	FATHER'S FAMILY	MOTHER'S FAMILY	SIBLINGS
ADHD					
Brain or neurological disease					
Developmental delay					
Epilepsy or seizure					
Genetic disorder					

CONDITION	FATHER	MOTHER	FATHER'S FAMILY	MOTHER'S FAMILY	SIBLINGS
Learning disorder					
Developmental delay					
Schizophrenia					
Bipolar disorder					
Anxiety disorder					
Panic disorder					
Obsessive-compulsive disorder					
Depressive disorder					
Speech and language disorder					
Other:					

PHYSICIAN INFORMATION

Name_____ Specialty_____ Phone _____

Name_____ Specialty_____ Phone _____

Name_____ Specialty_____ Phone _____

Are there any other things that I did not ask, or that you wanted me to know about your child that might help in my understanding of him/her:

Additional Notes:_____

Thank you for your time in completing this form.
This information is very valuable to the assessment process and will be used to help guide your child's evaluation.