
**THE ASSESSMENT CLINIC**
**at Shared Vision Psychological Services, Inc.**
1200 Harger Road, Suite 600, Oak Brook, Illinois 60523
Phone: 630-571-5750 Fax: 630-571-5751 Web: www.sharedvision.org

# PEDIATRIC NEUROPSYCHOLOGICAL INTERVIEW

**INSTRUCTIONS:** To provide a greater understanding of your assessment needs, 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:**_____ **Pronouns:**_____
**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 by this assessment?

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 your child born? (hospital, city, state) _____

Was your 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

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

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 birthing parent take any medications or have an X-ray during ☐Yes ☐No

Did the birthing parent drink alcohol during the pregnancy? ☐Yes ☐No

If so, how much: _____ How often: _____

Did the birthing parent use cocaine or any other recreational drugs during pregnancy ☐Yes ☐No

Did the birthing parent smoke cigarettes during the pregnancy? ☐Yes ☐ No

Did the birthing parent have any postpartum complications? ☐Yes ☐ No

Did the birthing parent experience postpartum depression, anxiety, mania, or psychosis? ☐Yes ☐ No

What was your child's birthweight? _____ lbs. _____ oz.

Did your child spend any time in the NICU after birth? If so, why? ☐Yes ☐No

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### *Infancy Information*

As an infant, did your 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: _____

_____

_____

_____

## DEVELOPMENTAL HISTORY

### *Developmental Milestones*

Was your child ever identified as eligible for early intervention services? If so, why?

Did any medical providers or teachers ever express concern regarding your child's developmental trajectory? Please provide any details below:

Did your child have difficulty meeting any of their early developmental milestones?

- ☐ Communication
- ☐ Feeding skills
- ☐ Gross motor skills (e.g. walking, jumping)
- ☐ Fine motor skills (e.g. using a spoon, holding a pencil)
- ☐ Sensory milestones

### *Temperament*

Describe your 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 your child attend preschool? ☐ Yes ☐ No If yes, at what age?_____

Describe any problems _____

What age did your child enter 1st grade?_____ If later than six, why?_____

What grade is your child currently in?_____

Current teacher's name:_____

Teacher's email address:_____

School name and address:_____

***Academic Achievement***

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

☐ Superior ☐ Above average ☐ Average ☐ Below average ☐ Failing

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

☐ Superior ☐ Above average ☐ Average ☐ Below average ☐ Failing

Has your child repeated any grades? ☐ Yes ☐ No If yes, which grade(s)_____

Has your child skipped any grades? ☐ Yes ☐ No If yes, which grade(s)_____

Most recent standardized testing scores (e.g. MAP, ASPIRE, PSAT, ACT), 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 your 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 your child receive special services at school? ☐Yes ☐No

Does your child hold an IEP or 504 plan? ☐Yes ☐No

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

- ☐ Speech and language
- ☐ Co-taught classroom
- ☐ 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
- ☐ 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 your 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 your child taking any medications? ☐ Yes ☐ No

If yes, please list below and indicate who is prescribing the medication:

| Name | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |

Are there noticeable side effects from any of your child's medications? ☐ Yes ☐ No

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

_____

_____

_____

Has your child been on previous medications for behavioral reasons? ☐ Yes ☐ No

If yes, please list:

_____

_____

_____

***Hospitalizations***

Has your 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 your child have difficulty getting along with children his/her age? ☐ Yes ☐ No
Does your child have difficulty getting along with adults? ☐ Yes ☐ No
Does your child have a closer relationship with one parent than the other? ☐ Yes ☐ No
Does your 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 your child involved in? _____

_____

_____

_____

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

_____

_____

_____

What special interests or talents does your 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 your 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 and what helps your child to calm?_____

_____

_____

_____

How long does it typically take for your child to return to baseline following dysregulation?

_____

_____

_____

***Other***

| | | |
|---|---|---|
| Are you aware of any physical abuse experienced by your child? | ☐ Yes | ☐No |
| Are you aware of any sexual abuse experienced by your child? | ☐ Yes | ☐No |
| Are you aware of any verbal abuse experienced by your child? | ☐ Yes | ☐No |
| Are you aware of any violence witnessed by your child? | ☐ Yes | ☐No |
| Has your child ever been arrested? | ☐ Yes | ☐ No |
| Has DCFS ever been involved in your child's care? | ☐Yes | ☐No |

If yes, please describe:

***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, schoolwork, or personal items at home | ☐ | ☐ |
| 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:<br>☐Omits sounds ☐Substitutes sounds ☐Distorts sounds | ☐ | ☐ |
| Fluency | ☐ | ☐ |
| Speaking in a monotone (very little emotion in speech) | ☐ | ☐ |
| 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<br>☐Is color blind | ☐ | ☐ |
| Recognizing objects or people the child should know | ☐ | ☐ |
| Dressing (tying shoes, pulling up zipper) not due to physical disability | ☐ | ☐ |
| Other: | ☐ | ☐ |

**ATTENTION**

| Child has difficulty with the following: | Old | New |
|---|---|---|
| Difficulty paying attention:<br>☐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 they leave work assignments or other objects | ☐ | ☐ |
| What happened recently (e.g. prior meal) | ☐ | ☐ |
| What happened days or weeks ago | ☐ | ☐ |
| School assignment | ☐ | ☐ |
| What they have 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 or gait ☐Left ☐Right | ☐ | ☐ |
| Involuntary or repetitive movements:<br>☐Eye/facial ☐Vocal ☐Limbs ☐Body | ☐ | ☐ |
| Oral (mouth) /motor or feeding | ☐ | ☐ |
| Other motor or coordination skills | ☐ | ☐ |

**SENSORY**

| Child has difficulty with the following: | Old | New |
|---|---|---|
| Vision ☐Left ☐Right | ☐ | ☐ |
| Hearing ☐Left ☐Right | ☐ | ☐ |
| Difficulty smelling or tasting food | ☐ | ☐ |
| Picky eating or feeding trouble | ☐ | ☐ |
| Toilet training | ☐ | ☐ |
| Under-responsive/over-responsive to pain or temperature | ☐ | ☐ |
| Overly sensitive to: ☐Touch ☐Light ☐Noise | ☐ | ☐ |
| Other sensory problems: | ☐ | ☐ |

**BEHAVIORS**

| Child exhibits the following: | Old | New |
|---|---|---|
| Aggressive to people, animals, or property | ☐ | ☐ |
| Craving or eating of non-food substances | ☐ | ☐ |
| Depressed | ☐ | ☐ |
| Poor or unusual eating habits | ☐ | ☐ |
| 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 | ☐ | ☐ |
| Risky (dangerous) behaviors | ☐ | ☐ |
| Stomach aches | ☐ | ☐ |
| Suicidal acts or statements | ☐ | ☐ |
| Withdrawn | ☐ | ☐ |
| Other: | ☐ | ☐ |

## FAMILY HISTORY

***Immediate Family***
Please complete the following:

| RELATIONSHIP | NAME/ AGE | EDUCATION/ OCCUPATION | LIVING WITH CLIENT |
|---|---|---|---|
| ☐Parent /☐Guardian | | | ☐Yes☐No |
| ☐Parent /☐Guardian | | | ☐Yes☐No |
| Sibling | | | ☐Yes☐No |
| Sibling | | | ☐Yes☐No |
| Sibling | | | ☐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 your 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 your child'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.*