The Neuropsychology Center

Background Questionnaire for Children

Today's Date____ /_____ /_____

Child's Name__________________________________ DOB____ / _____ / _____ Age_______

Name of person completing form_______________________________________

Relation to child: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Other_________________________

Status of child's parents: ☐ Married ☐ Separated ☐ Divorced ☐ Never married

Mother's education / occupation___________________________/__________________________________

Father's education / occupation____________________________/__________________________________

List of people living at home with child

Name	Age	Relationship to child

School________________________________ Teacher____________________________ Grade_______

Briefly describe your concerns regarding your child:____

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How long have you been concerned____

Has your child undergone previous evaluation or testing? ☐ Yes ☐ No

If yes, who evaluated your child and what were the results___________________________________

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Is your child taking any medications? ☐ Yes ☐ No

If yes, please list their names____

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PREGNANCY / DELIVERY

Did the child's mother experience any problems during pregnancy (such as unusual bleeding, high blood pressure, infection, other serious medical problems)? ☐ Yes ☐ No

If yes, please explain____

Did the child's mother smoke or drink alcoholic beverages (more than 1-2 drinks per week) during pregnancy? ☐ Yes ☐ No

If yes, please explain____

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Was the child carried full-term ☐ Yes ☐ No If no, how many weeks premature? ________

Were there any complications during labor or delivery? ☐ Yes ☐ No

If yes, please explain____

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Birthweight___ lbs. ___ oz.

DEVELOPMENTAL HISTORY

Did the child experience any medical problems during the first year? ☐ Yes ☐ No

If yes, please explain____

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Milestones: Please estimate at what age the child first demonstrated these behaviors.

	Age		Age
Sat alone	____	Spoke first word	____
Crawled	____	Used two-word phrase	____
Stood alone	____	Potty trained during day	____
Walked alone	____	Stayed dry at night	____
Babbled	____	Said alphabet	____

MEDICAL HISTORY

Please check any conditions that the child has had.

- ☐ Measles
- ☐ German measles
- ☐ Mumps
- ☐ Chicken pox
- ☐ Whooping cough
- ☐ Diphtheria
- ☐ Polio
- ☐ Scarlet fever
- ☐ Meningitis
- ☐ Encephalitis
- ☐ High fever
- ☐ Convulsions / Seizures
- ☐ Serious head injuries
- ☐ Hearing problems
- ☐ Ear infections
- ☐ Vision problems
- ☐ Loss of consciousness
- ☐ Dizziness
- ☐ Frequent headaches
- ☐ Rheumatic fever
- ☐ Anemia
- ☐ Hepatitis
- ☐ Diabetes
- ☐ Cancer
- ☐ High blood pressure
- ☐ Heart problems
- ☐ Asthma

Other medical problems?____

____

____

FAMILY MEDICAL HISTORY

Please check any conditions that immediate family members have had.

	Relationship to child		Relationship to child
☐ Alcoholism	________________	☐ Genetic disorder	________________
☐ Deafness	________________	☐ Hyperactivity	________________
☐ Depression	________________	☐ Learning disorder	________________
☐ Developmental problems	________________	☐ Mental illness	________________
☐ Drug problem	________________	☐ Mental retardation	________________
☐ Emotional problem	________________	☐ Neurological disorder	________________
☐ Epilepsy	________________		