CONFIDENTIAL INFORMATION

Pediatric Neuropsychology Parent/Caregiver Intake Form

*****Please complete and bring the following form with you to your child's appointment to Neuropsychology Partners. Please also bring educational documents (e.g., IEP, 504 plan, any report cards you have) and an prior psychological or neuropsychological testing. If we do not have this information your child's evaluation may be delayed.**

Child's Name: Date of Birth:

Sex assigned at birth: Male Female Unknown Child's preferred pronouns:

Child's preferred gender: Primary Care Physician/Clinic:

Handedness: Right Left Both Neither City lives in:

Name of person filling out form:

Current concerns & how long have you had these concerns?

What are you hoping to achieve with this evaluation?

Why are you pursuing this evaluation now?

Is this an evaluation for legal purposes, disability, or guardianship? *(circle)* Yes No

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Child's strengths:

With whom does the child live?	Name	Age	Relationship to child

Any custody or visitation arrangements (e.g., 50/50, changes to legal custody, primary placement)?

Siblings outside of the home?	Name	Age	Gender

BIRTH HISTORY

Adopted?   No International National   Is child aware?   Yes   No

Length of Pregnancy? ______________________ Birth Weight: ____________

Prenatal Care?   Yes   No   Unknown

Delivery *(circle all that apply)*:

Vaginal   Planned C-Section   Emergency C-Section   Breech   Unknown

Pregnancy/Labor/Delivery Complications (e.g., NICU, jaundice, infant given oxygen)?

Drug/Alcohol/Nicotine/Medication/Significant Stress during pregnancy?

Any concerns in the first few months of life?

Did child excessively cry early on, within their first couple years following birth?

As an infant/young child did the child show age appropriate social interaction (e.g., smiling, cooing, good eye contact, interest in parents)?

DEVELOPMENTAL HISTORY

Developmental milestones? *(can indicate "not yet", if no concerns just indicate no concerns)*

Crawled: ______________________________

Walked independently: ______________________________

First word: ______________________________

Used phrases: ______________________________

Toiled trained for day: ______________________________

Toiled trained for night: ______________________________

Tied Shoes: ______________________________

Biking no training wheels: ______________________________

Swam independently: ______________________________

Early Intervention Services? (circle all that apply)
Birth to Three   Early Childhood   Head Start
Physical Therapy   Occupational Therapy   Speech Therapy

Does the child have a history of any of the following *(check all that apply)*:

ADHD	☐	Alcohol/Substance Abuse	☐
Autism Spectrum Disorder	☐	Anxiety	☐
Bedwetting	☐	Cancer	☐
Cerebral Palsy	☐	Concussion	☐
Constipation	☐	Depression	☐
Diabetes	☐	Diarrhea	☐
Developmental Delay	☐	Dyslexia	☐
Epilepsy	☐	Feeding Problems	☐
Headaches	☐	Hearing Loss	☐
Language Disorder	☐	Lead Poisoning	☐
Learning Disorder	☐	Loss of Consciousness	☐
Motor Delays	☐	Seizures	☐
Sleep problems	☐	Snoring	☐
Stomachaches	☐	Sensory Sensitivities	☐
Social Skills Problems	☐	Surgeries/Hospitalizations	☐
Repetitive Behaviors	☐	Vision Difficulty	☐
Heightened/odd Interests	☐	MRI/CT/EEG testing	☐
Environment/food Allergies	☐	Allergies to drugs/medicine	☐

Any repetitive behaviors (e.g., repeat phrases, hand flapping, pacing, spinning, wrist twisting)?

Any issues with aggression?

Tantrums? What triggers? Describe tantrum (e.g., crying, whining, aggression, self-injury)? How long last? How frequent? How do they resolve?

Does child have friends? Any concerns?

Any concerns with eating habits (e.g., picky, texture preferences, overeating, restricting)?

Any sleep concerns?

Any history of physical or sexual abuse? Verbal abuse? Witness domestic violence?

Has child experienced significant losses, moves, stressors, trauma?

Current Medications: (if there are many medications you can attack a list)

Drug *Dosage* *How long?*

Vitamins, nutrition supplements, over-the-counter medications, or non-prescribed substances?

How is the family and child's support system (e.g., family, friends, church)?

Any previous neuropsychological/psychological Testing? If so, please report year and child's age at time of assessment.

Is/has the child been in family therapy and/or individual counseling, behavioral therapy or any psychological treatment?

If so, how long: Frequency (x1/week or x1/year): Who:

EDUCATIONAL HISTORY

Type of School (circle) Public Private Home Charter Online

Supports (circle): IEP 504plan Health Service Plan interventions tutoring agency

Name of School: ______________________________ Grade: __________

Repeated a grade? ______________________________ Skipped a grade? __________

Grades (circle one): Above grade level Grade level Below grade level
GPA (if known):

Attendance Concerns? ______________________________

Tutoring or support outside of school? ______________________________

How did your child do during the COVID-19 pandemic? Virtual school? How did this go? ______________________________

Are you concerned your child has not had access to good education? If so, explain: ______________________________

Please indicate if there is a biological family history of any of the following *(check all that apply)*:

	Child's Mom's Family	Child's Dad's Family
ADHD		
Alcoholism/Drug Abuse		
Anxiety Disorders		
Autism Spectrum Disorders		
Bipolar Disorder		
Depression		
Developmental Delay		
Learning Disability		
Mental Retardation		
Schizophrenia		
Seizures		
Other:		

Comments:

PARENT/CAREGIVER INFORMATION

PARENT/CAREGIVER#1

Name: ______________________ Relationship: ____________

Level of Education: ______________________ Age: ____________

Occupation: ______________________

PARENT/CAREGIVER#2

Name: ______________________ Relationship: ____________

Level of Education: ______________________ Age: ____________

Occupation: ______________________

PARENT/CAREGIVER#3

Name: ______________________ Relationship: ____________

Level of Education: ______________________ Age: ____________

Occupation: ______________________

PARENT/CAREGIVER#4

Name: ______________________ Relationship: ____________

Level of Education: ______________________ Age: ____________

Occupation: ______________________

Additional Comments: