Neurobehavioral History

Child's Name________________________________ **Date Completed** ___/___/___

Date of Birth ___/___/___ **Child is: __Biological __Adopted__Foster**

Child's Gender at Birth:____________________________

Child's Preferred Gender Identity:____________ **Child's Preferred Pronouns:**___________________

Form Completed by: ___ **Parent** ___ **Guardian** ___ **Other**__________________

Parent#1 completed education: ________________ **Parent#1 occupation:** _____________________

Parent#2 completed education: ________________ **Parent#2 occupation:** _____________________

Parents are: ___ Married ___ Separated ___ Divorced ___ Cohabitating (not married)

If divorced, please describe custody arrangement:____

Individuals living in home:

Name	Age	Relationship to child
____________________	________	____________________________
____________________	________	____________________________
____________________	________	____________________________
____________________	________	____________________________

Child participates in: ___ Childcare (# hours per day ____) ___ Before/after school programming

Please list any medications taken by your child:

Name of Medication	Reason for Taking	Dose (how much)
_______________________	_______________________	________________________
_______________________	_______________________	________________________
_______________________	_______________________	________________________

Reason for Evaluation:____
____
____
____

In your opinion, the major cause/s of your child's difficulties: ___________________________________
____
____
____

Do all parents/caregivers agree about the nature of the problem? ________________________________
____
____
____

Birth and Developmental History

Was your child born:
___ Early (____ weeks old at birth) ___ On Time ___ Late

Were there any complications:

During the pregnancy? **Yes** **No**
If yes, please describe:____
____

During the delivery/birth? **Yes** **No**
If yes, please describe:____
____

Did your child have a low birth weight? **Yes** **No**
If so, please list weight: _______ lbs. ______oz.

Were any of the following used during pregnancy:

___ Cigarettes	___ 1-10 per day	___ 10-20 per day	___ >1 pack per day
___ Alcohol	___ daily	___ weekly	___ daily
___ Other Substances	___ daily	___ weekly	___ monthly

List type of substances used____

Please place a √ to indicate when the following developmental milestones were achieved:

	Early	On Time	Late
Motor (e.g., walk, crawl)	___	___	___
Speech	___	___	___
Toilet Training	___	___	___

Medical History

Please list any medical diagnoses your child has received:
____
____
____
____

Has your child ever been hospitalized due to a major illness or injury? **Yes** **No**
If so, for how long? _____________________________________
What type of illness or injury? ______________________________

Has your child experienced any of the following (√ all that apply):
___ Exposure to lead (e.g., paint, pipes)
___ Febrile seizures (seizure as an infant) or fever that resulted in confusion/unusual behavior
___ Carbon monoxide poisoning
___ Exposure to trauma/violence
___ Poisoning
___ Near-drowning (e.g., restricted oxygen supply)

Does any other family member have a problem similar to the one that your child is being seen for?
____
____

Is there a history of medical problems in any family members (e.g., mother, father, siblings, grandparents, etc.)?
____
____

Is there a history of neurological problems in any family members (e.g., mother, father, siblings, grandparents, etc.)?
____
____

Is there a history of seizures in any family members (e.g., mother, father, siblings, grandparents, etc.)?
____
____

Is there a history of learning difficulties in any family members (e.g., mother, father, siblings, grandparents, etc.)?
____
____

Is there a history of psychiatric problems in any family members (e.g., mother, father, siblings, grandparents, etc.)?
____
____

"Bumps to the Head"

Has your child ever received a "bump to the head" or concussion that caused you to be concerned?
(for example, hit their head on the ground or windshield)
If so, please provide the following information:

When did the event occur? _____(mo)/_____(year)

How did your child receive a "bump to the head" or concussion?
___ Fall
___ Assault
___ Motor Vehicle Accident
___ other (please describe____)

Please describe what happened:
____
____
____
____

	(Please circle)	
Were they seen in the Emergency Room as a result?	**Yes**	**No**
Was your child admitted to the hospital?	**Yes**	**No**

If yes, for how long?
___ < 24 hours ___ 24-48 hours
___48 hours-1 week ___ more than 1 week

Were they seen in the doctor's office?	**Yes**	**No**
Did they have x-rays or head films taken (e.g., MRI, CT)?	**Yes**	**No**

If so, please describe results__________________
____

Did your child lose consciousness (at the time of the injury or within 48 hours)?	**Yes**	**No**

If yes, for how long?
___ <1 minute ___ 2-5 minutes ___ 5-30 minutes
___ >1 hour ___ >24 hours

In the days following the event, did your child:

become dizzy, nauseous, or complain or a headache?	**Yes**	**No**
become confused?	**Yes**	**No**

If so, for how long:
___ <1 hour ___ 1-24 hours ___>1 week ___ >1 month

have problems with their memory or thinking skills?	**Yes**	**No**
become unusually moody or easily frustrated?	**Yes**	**No**

School Information

Child's Grade in School _____ Has your child repeated a grade? ___ Yes ___ No
If yes, which grade/s? _________

Type of Classroom or School Program: (check one or all that apply)
___ Regular Classes
___ Regular Classes plus Special Services (e.g., resource room, speech therapy)
___ Self-contained Special Education class with integration into regular classes
___ Self-contained Special education classroom
___ Home Schooled – Online school program
___ Other (Describe____)

Has your child received a psychological or educational evaluation at school or privately? ___ Yes ___ No
If yes, when?____

Please describe special education services your child currently receives or has received in the past:
____
____
____

Educational History

Compared to other children of the same age, how would you describe your child's:

	Far Below Average	Below Average	Average	Above Average	Well Above Average
Ability and Intelligence	___	___	___	___	___
School Achievement	___	___	___	___	___
Academic achievement in:					
Reading/English	___	___	___	___	___
Math	___	___	___	___	___
Science	___	___	___	___	___
Social Studies	___	___	___	___	___
Writing	___	___	___	___	___
Effort in school	___	___	___	___	___
School attendance	___	___	___	___	___

Does your child have an Individualized Education Plan (IEP) or 504 Plan? **Yes** **No**
If so, for what area/s?______________________________________

Has your child been diagnosed with a learning disability? **Yes** **No**
If so, at what age were they diagnosed? ____________________
Type of learning disability:
___ Reading
___ Math
___ Writing
___ Nonverbal
___ Other (please describe:_____________________)

Please describe your child's academic strengths:____

Mental Health History

Has your child been diagnosed with a psychological or psychiatric problem? **Yes** **No**

If so, please describe ____
____

Did they receive treatment for the problem? **Yes** **No**

If so, please describe ____
____

When did the problem begin?____

Has your child ever had problems with alcohol or drug use? **Yes** **No**

If so, please indicate what type/s:
____
____

Has your child ever received treatment for drug or alcohol related problems? **Yes** **No**

Is your family currently experiencing a significant amount of stress? **Yes** **No**

If so, please describe ____
____
____
____

How would you describe your child's relationship with peers:

___ well-liked ___ a few close friends ___ no close friends
___ tolerated ___ avoided

Has your child received detentions or suspensions from school? **Yes** **No**

How often does this happen?

___ daily ___ weekly ___ monthly ___ several times per year

The detentions/suspensions are usually a result of:

___ incomplete work ___ skipping class ___fighting
___ not getting along with teachers ___ other (describe________________________)

Activities & Interests

Please indicate if your child participates in any of the following athletic activities:

___ soccer	___ cheerleading	___hockey
___ gymnastics/tumbling	___ football	___lacrosse
___ martial arts	___ baseball/softball	___field hockey
___ basketball	___ swimming	___volleyball
___ other (______________________________)		

Does your child wear a helmet when bicycling, roller skating, skateboarding, etc? **Yes** **No**

Please indicate whether your child participates in any of the following:

___ chorus	___ leadership
___ band	___ gifted and talented program
___ orchestra	___ debate team
___ school newspaper	___ yearbook staff
___ drama/theater	___ 4-H
___ dance	___ FFA (Future Farmers of America)
___ girl or boy scouts	___ student council/government
___ clubs (e.g., pep club)	___ other (________________________)

Please indicate if you consider any of the following to be a strength for your child:

___ musical ability
___ artistic ability
___ academics
___ athletics
___ other (____________________________)

Please indicate how your child prefers to spend their free time:

___ videogames
___ with friends
___ reading
___ watching television
___ outside
___ computer
___ other (___________________________)

How much time do you estimate your child spends using screens per day?
___ 1-2 hours
___ 2-4 hours
___ 4-5 hours
___ more than 5 hours