PEACHTREE NEUROPSYCHOLOGICAL ASSOCIATES, P.C.

Thomas G. Burns, Psy. D., ABPP Board Certified in Clinical & Neuropsychology

CONFIDENTIAL CHILD PATIENT QUESTIONNAIRE

IDENTIFYING INFORMATION:

Child's Name _____ Date of Birth ___ / ___ / ___

Parents' Names _____ Date of Interview ___ / ___ / ___

Address _____ Date of Evaluation ___ / ___ / ___

_____ Male _____ Female _____

Phone Home: _____ Age: _____

Cell: _____

Work: _____ Handedness: Right___Left___Both___

Which of the following best describes your child? (Please check one)

___ White, not of Hispanic origin

___ African American or Black, not of Hispanic origin

___ Hispanic

___ Native American Indian or Alaskan Native

___ Asian, Asian-American, or Pacific Islander

___ Other: _____

Referred by (Who suggested that your child have this evaluation):

_____

_____

Is there a lawyer involved in this case? yes___ no___ If yes, explain? _____

_____

_____

Reason for referral and parental concerns (Please describe in detail the problems that are affecting your child and family):

_____

_____

_____

_____

_____

Child's Diagnosis: _____

Person completing form: _____

p.770-220-0887

Lakeside Commons
990 Hammond Drive
Suite #575
Atlanta GA 30328

www.PeachtreeNeuropsych.com

Relationship to child:_____ Today's date_____

PREGNANCY AND NEWBORN HISTORY

Mother's health during pregnancy (please check yes or no):

Had to take prescription medications: ___yes ___no

If yes, please list medication: _____ _____ _____ _____

Bleeding:	___yes	___no	Drug use:	___yes	___no
Toxemia	___yes	___no	Serious Injury:	___yes	___no
High blood pressure:	___yes	___no	Smoked cigarettes:	___yes	___no
Alcohol use:	___yes	___no	Diabetes:	___yes	___no
Fever or rash	___yes	___no	Infection or other illness:	___yes	___no

Pregnancy and Delivery:

Length of pregnancy (how many weeks?): _____

Number of previous live births: _____

Number of previous pregnancies _____

Length of labor: _____

Child's birth weight: ___ pounds ___ ounces

Delivery was by: ___Vaginal ___ C-section

Apgar score at: ___1 minute ___ 5 minutes

Special Care Nursery?: ___yes ___ no

If yes, length of hospitalization: _____

Problems with delivery?: ___yes ___no

If yes, please explain: _____

_____

Were forceps/vacuum used?: ___yes ___no

Was it a breech birth?: ___yes ___no

Did the baby…

Have trouble breathing: ___yes ___no

Turn blue (cyanosis): ___yes ___no

Need oxygen: ___yes ___no

Turn yellow (jaundice): ___yes ___no

DEVELOPMENTAL HISTORY

At what age did your child:	Age	Problems/Comments
Sit alone	_____	_____
Walk	_____	_____
Crawl	_____	_____
Speak first word	_____	_____
Understand speech	_____	_____
Speak two word sentences	_____	_____
Toilet trained for day	_____	_____
Toilet trained for night	_____	_____

Does your child have a history of speech and language problems? __yes ___no

Does your child have a history of motor problems? __yes ___no

MEDICAL HISTORY:

Please check and identify the age at which your child experienced and of the following:

Colic:	___	age: ___		Comments
Feeding problems:	___	age: ___		
Sleep problems:	___	age: ___		
Ear infections:	___	age: ___		
Head injury:	___	age: ___	Unconscious? __Yes __ No	
Seizures:	___	age: ___		
Meningitis:	___	age: ___		
Encephalitis:	___	age: ___		
Frequent/Severe headaches:	___	age: ___		
Frequent abdominal pain/nausea:	___	age: ___		
Allergies:	___	age: ___		
Asthma:	___	age: ___		
Hospitalizations:	___	age: ___		
Surgeries:	___	age: ___		
Eye or visual exam problems:	___	age: ___		
Hearing or evaluation problems:	___	age: ___		
Other condition(s):	___	age: ___		
Other illness(es):	___	age: ___		

Has your child undergone the following:

Neurological evaluation:	___	age: ___	Comments
Electroencephalogram (EEG):	___	age: ___	
Scans of the Brain (CT, MRI):	___	age: ___	
Occupational Therapy Evaluation:	___	age: ___	
Speech/Language Evaluation:	___	age: ___	
Physical Therapy Evaluation:	___	age: ___	
Hearing/Vision Evaluation:	___	age: ___	
Neuropsychological Evaluation:	___	age: ___	
Psychological Evaluation:	___	age: ___	
Psychiatric Evaluation:	___	age: ___	

Pediatrician Name/Practice: _____

Other Medical Specialists: Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Current Medications: **Helpful?** **Past Medications:** **Helpful?**

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

Has your child ever received any of the following forms of psychological treatment?

Individual psychotherapy ___yes ___no If yes, when:_____

Group therapy ___yes ___no If yes, when:_____

Family therapy ___yes ___no If yes, when:_____

Inpatient psychiatric treatment ___yes ___no If yes, when:_____

EDUCATIONAL BACKGROUND:

Name of preschool: _____ Any Concerns? _____

Name of elementary school: _____ Any Concerns? _____

Current grade: _____ County: _____

Name of current school: _____ Any Concerns? _____

Has your child ever repeated a grade: ___yes ___no If yes, what grades? _____

Has your child ever received the following services:

Early Intervention/Babies Can't Wait ___yes ___no Age _____

Speech/language therapy ___yes ___no Age _____

Physical therapy ___yes ___no Age _____

Occupational therapy ___yes ___no Age _____

Individualized Education Program (IEP) ___yes ___no Age _____

Eligibility classification (e.g., Other Health Impaired, Significant Developmental Delay): _____

Student Support Team (SST) ___yes ___no Age _____

Response to Intervention Monitoring (RTI) ___yes ___no Age _____

Please describe any Special Education Services:

_____

_____

FAMILY/SOCIAL HISTORY:

The following information is about (check one):

___Biological parent(s) ___Adoptive parent(s) ___Step-parent(s)

Mother: Name:_____ Occupation:_____ Age:_____

Years of school completed: ___Less than 7th grade ___7th to 9th grade ___10th to 11th grade

___High school graduate ___ At least 1 year of college/vocational training or associate's degree

___College graduate ___Graduate degree

Father: Name:_____ Occupation:_____ Age:_____

Years of school completed: ___Less than 7th grade ___7th to 9th grade ___10th to 11th grade

___High school graduate ___ At least 1 year of college/vocational training or associate's degree

___College graduate ___Graduate degree

Income Range _____ $7,000-$31,000 _____ $32,000-$71,000 _____ $72,000-$100,000 _____ above $100,000

Parents are: ___Married ___Separated ___Divorced ___Single ___Widowed

Who currently lives in the home with the child?_____

	Full sibling	Half-sibling	Step-sibling
Siblings: Name _____ Age_____ Grade_____	_____	_____	_____
Name _____ Age_____ Grade_____	_____	_____	_____
Name _____ Age_____ Grade_____	_____	_____	_____
Name _____ Age_____ Grade_____	_____	_____	_____

SIGNIFICANT FAMILY INFORMATION:

Has anyone in your immediate or extended family experienced the following? (besides your child)

Speech or language problems	___yes	___no	If yes, who?_____
Held back in school	___yes	___no	If yes, who?_____
Mental retardation	___yes	___no	If yes, who?_____
Attention-deficit/hyperactivity disorder (ADD/ADHD)	___yes	___no	If yes, who?_____
Genetic disorder	___yes	___no	If yes, who?_____
Trouble learning to read	___yes	___no	If yes, who?_____
Suicide or attempted suicide	___yes	___no	If yes, who?_____
Depression	___yes	___no	If yes, who?_____
Anxiety or panic attacks	___yes	___no	If yes, who?_____
Bipolar disorder	___yes	___no	If yes, who?_____
Seizures	___yes	___no	If yes, who?_____

CHILD'S BEHAVIOR:

Has your child ever demonstrated:

Unusual behaviors/tics	___yes	___no	If yes, explain?_____
Suspension from school	___yes	___no	If yes, explain?_____
Expulsion from school	___yes	___no	If yes, explain?_____
Problems with peer relationships	___yes	___no	If yes, explain?_____
Any sudden changes in behavior	___yes	___no	If yes, explain?_____
Difficulty getting along with adults	___yes	___no	If yes, explain?_____
Significant conflict with parent	___yes	___no	If yes, explain?_____

Discipline:

Please check the types of discipline you use at home for your child's behavior:

___Time out	___Praise/reward good behavior
___Take things away	___Yelling
___Spanking	___Ignore
___Grounding	___Extra chores

Please describe how well these methods work:_____

Please list your child's hobbies or extracurricular activities:_____

_____

Please list organizations that your child belongs to (e.g., Boy Scouts, Girls Scouts, 4H…):_____

_____

Please list your child's strengths:_____

Please list your child's weaknesses:_____

Is there anything else we didn't ask you that you would like us to know? _____

_____

_____

Thank you for completing this form!

- Dr. Burns

AUTHORIZATION FOR RELEASE OF MEDICAL, EDUCATION, AND/OR PSYCHOLOGICAL INFORMATION

Please list the name, address, and/or phone number of the individuals to where you would like copies of the final Neuropsychological Report sent. The release of information provided below will serve as your permission to send the report and consult with the individuals that are listed:

I, _____ representing _____ ___/____/___, authorize
(Patient or Personal Representative) (Patient) (Patient's Date of Birth)

Dr. Thomas G. Burns and Peachtree Neuropsychological Associates, P.C. to release and obtain information from the following individuals:

Name: _____ Address: _____
_____
Telephone: _____

Name: _____ Address: _____
_____
Telephone: _____

Name: _____ Address: _____
_____
Telephone: _____

Name: _____ Address: _____
_____
Telephone: _____

The purpose for this disclosure is for Neuropsychological Assessment and Follow-up.

I have read, or had read to me, the above statements, and understand them as they apply to me. I further understand that I may revoke this consent at any time, except to the extent that action has already been taken in accord with this consent. In any event, this consent will expire (unless expressly revoked earlier) thirty-six (36) months from the date signed by the patient or legally authorize agent. Additionally, I have been given the opportunity to review the Patient Privacy Notice required by HIPAA and may request a copy if I so desire.

_____ ____ / ____ / ____
(Signature of Patient or Personal Representative) (Date)

_____
(Description of Personal Representative's Authority)

_____ ____ / ____ / ____
(Witness) (Date)

**** Note: Please provide copies of any previous assessments, medical reports, and/or academic records that would be helpful in working with your child.

Thank you for your cooperation,
Dr. Burns