TREEHOUSE PSYCHOLOGY, PLLC

NEURODEVELOPMENTAL HISTORY FORM

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Child's Name:

_____

Today's Date:

_____

DOB:

_____

What concerns you most about your child?

_____
_____
_____
_____
_____
_____
_____

What are you hoping to learn/understand about your child by having this evaluation?

_____
_____
_____
_____
_____
_____

Does your child have a current diagnosis? (If yes, please list below and who provided diagnosis):

_____
_____
_____
_____

FAMILY HISTORY

Parents (circle): Married Separated Divorced Living Together

Biological Mother: _____ Age: _____
Education/Highest Grade: _____
Current Employment: _____

Biological Father: _____ Age: _____
Education/Highest Grade: _____
Current Employment: _____

Adoptive/Step/Foster Mother: _____ Age: _____
Education/Highest Grade: _____
Current Employment: _____

Adoptive/Step/Foster Father: _____Age: _____
Education/Highest Grade: _____
Current Employment: _____

Guardian/PCA/Behavioral Aide: _____ Age: _____

Additional Children in Family: (biological, adopted or foster)

Name:	Age:	Medical/Social/School Problems?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLACEMENT HISTORY:

Who currently has physical custody of the child? _____
Who currently has legal custody of the child? _____
Adopted? YES NO

If yes, date of adoption and country: _____

History of Foster Care? YES NO
If yes, what was the age of child at first out of home placement? _____
How many out of home placements have there been? _____
Please list all placements and dates:

_____
_____
_____
_____
_____
_____

Has this child received child protection services at any point in time? YESNO
If yes, please describe: _____
_____
_____
_____
_____

BIOLOGICAL FAMILY HISTORY

Please check history of the following in biological parents' family (immediate and extended):

Mother's Side:
_____ Learning Problems
_____ School Problems
_____ Inattention/Poor Concentration
_____ Hyperactivity/Impulsivity
_____ Anxiety
_____ Depression
_____ Obsessive Compulsive Problems
_____ Alcoholism
_____ Drug Dependence
_____ Developmental Disability
_____ Mental Handicap
_____ Autism Spectrum Disorder
_____ Bipolar Disorder
_____ Seizure Disorder
_____ Genetic Disorder
_____ Trauma
_____ Other

Father's Side:
_____ Learning Problems
_____ School Problems
_____ Inattention/Poor Concentration
_____ Hyperactivity/Impulsivity
_____ Anxiety
_____ Depression
_____ Obsessive Compulsive Problems
_____ Alcoholism
_____ Drug Dependence
_____ Developmental Disability
_____ Mental Handicap
_____ Autism Spectrum Disorder
_____ Bipolar Disorder
_____ Seizure Disorder
_____ Genetic Disorder
_____ Trauma
_____ Other

_____

SOCIAL HISTORY:

Describe general family relationships:
_____
_____
_____
_____
_____

Have there been any abuse issues in the family? (e.g., emotional, physical, sexual)
If yes, please explain briefly:

_____
_____
_____
_____

PRENATAL INFORMATION AND EARLY DEVELOPMENT:

How many weeks was pregnancy? (normal is 38-40) _____

List medications taken during pregnancy (prescribed and non-prescribed):

_____
_____
_____
_____
_____

Child's birth weight: _____ Child's length:_____
APGAR scores: 1 minute: _____ 5 minutes: _____

Were any of the following consumed during pregnancy?			When/Amount?
ALCOHOL	YES	NO	_____
TOBACCO	YES	NO	_____
COCAINE	YES	NO	_____
MARIJUANA	YES	NO	_____
METHAMPHETAMINES	YES	NO	_____
PSYCHOTROPIC DRUGS	YES	NO	_____

List any difficulties during pregnancy:

_____
_____

Were there problems with labor? _____
_____

Were there difficulties with the child immediately after birth? YES NO
If yes, please explain: _____
_____

Were the following used: forceps suction medications

Check all that apply:

Bronchopulmonary dysplasia Pneumonia Retinopathy of prematurity
Intraventricular Hemorrhage Congenital Heart Defect Infections
Jaundice/Hyperbilirubinemia

Did the child receive:

Intubation	Oxygen	Surfactant	Antibiotics
Chest tube	Surgery	Umbilical Catheter	Feeding Tube

AT WHAT POINT DID YOU *FIRST* BECOME CONCERNED WITH YOUR CHILD'S DEVELOPMENT?

_____
_____
_____
_____
_____
_____
_____

Developmental Milestones: (please state in months or years)

___ Rolled over	___ First words	____ Bladder training (day)
___ Sat alone	___ First sentences	____ Bladder training (night)
___ Crawled	___ Understood 'no'	____ Bowel training
___ Walked	___ held crayon	____ used a bicycle

Age of puberty: _____ Sex education provided at home? YES/NO
Is your child sexually active? _____
Is your child using birth control? _____
Are there any concerning sexual behaviors? _____
_____

Check problems below that were present during Infancy (0-18 mo), Toddler (18 mo-3 years) or Preschool (3-5 years)

I = Infancy T=Toddler P=Preschool

____ High Fevers
____ Recurrent ear infections or tubes placed
____ Hearing loss
____ Colic/reflux

____ Lead exposure
____ Poor weight gain/poor feeding
____ Lethargy
____ Restlessness
____ Poor sleep
____ Difficult to calm or pacify
____ Did not like being held/stiffened when held
____ Aggression
____ Thumb sucking
____ Separation anxiety
____ hypersensitive to sights, sound, touch
____ head banging or other repetitive behaviors
____ spinning, rocking, toe-walking
____ nightmares or night terrors
____ Clumsy/poor coordination/accident proneness
____ hypotonia or hypertonia
____ high pain tolerance
____ poor eye contact
____ hypersexual behaviors
____ unusual play behaviors
____ poor social skills/difficulty getting along with others

Check the behaviors your child **currently** exhibits to an exaggerated degree in comparison to others his/her age:

___ high activity
___ poor attention
___ interrupts frequently
___ immaturity
___ sad mood
___ separation anxiety
___ learning problems
___ seems driven by 'motor'
___ heedless to danger
___ difficulty finishing tasks
___ tics/twitching
___ gets lost easily
___ overly friendly
___ bingeing, purging
___ suicidal ideation
___ says things over and over
___ just seems 'different'
___ other concerning behaviors

____ impulsivity/poor self-control
____ difficulty learning from experience
____ socially awkward
____ social withdrawal
____ worried or anxious
____ poor awareness of time
____ aggression
____ temper outbursts
____ poor coordination
____ disorganized
____ poor response to discipline
____ runs off
____ sees or hears things that are not there
____ self-harm behaviors
____ bedwetting
____ problems with transitions/change activities
____ sensitivity to sights and sounds or touch

Other Concerns:

_____
_____
_____
_____

WHAT ARE THE BEHAVIORS THAT MOST INTERFERE WITH DAILY FUNCTIONING?

_____
_____
_____
_____
_____
_____
_____

Does your child exhibit any of the following (circle)?

Lying/cheating Vandalism/stealing History of sexual perpetration
Alcohol or drug abuse Violent behavior Cruelty toward animals
Hypersexual behaviors Cutting or burning self Suicide threats or gestures

What type of discipline is used with your child?

_____

Do you find these effective?

_____

Have you attended any parenting courses?

YES NO

Please describe: _____

_____
_____

SOCIAL SKILLS

Does your child seek out friends?	Always	Often	Sometimes	Never
Do other children approach him/her?	Always	Often	Sometimes	Never
Does your child relate well to others?	Always	Often	Sometimes	Never
Does your child seem to understand the rules of social interaction?	Always	Often	Sometimes	Never

Please list any concerning social behaviors/problems with friendships:

_____
_____
_____
_____
_____

Are there concerns for your child related to social vulnerability?

____ Easily led by others
____ Avoids confrontation
____ Vulnerable to peer pressure
____ Does not make good choices with peers
____ Social immaturity
____ history of being victimized or bullied by peers

SCHOOL EXPERIENCE:

Current school: _____
Location: _____
Grade: _____

Does your child (or has your child) received ECSE? YES NO
Describe: _____
Does your child (or has your child) participated in preschool? YES NO
Describe: _____

Does your child currently receive special education services? YES NO
Does your child have an Individual Education Plan? YES NO
504 Accommodation Plan? YES NO

What is your child's current special education classification?

- OTHER HEALTH DISABLED (OHD)
- EMOTIONAL/ BEHAVIORAL DISORDER (EBD)
- SPECIFIC LEARNING DISABILITY (SPD)
- AUTISM SPECTRUM DISORDER (ASD)
- SPEECH OR LANGUAGE DISORDERED (SLD)
- DEVELOPMENTAL DELAY (DD)
- HEARING IMPAIRED
- VISUALLY HANDICAPPED
- ENGLISH SECOND LANGUAGE

Describe your child's current academic performance:

_____
_____
_____
_____
_____

Does your child receive any of the following in school: (circle)

adapted physical education	physical therapy	speech therapy
occupational therapy	counseling	tutoring

When was your child's last IEP evaluation (3 year evaluation)? _____

Circle all problems reported by teachers:	Poor work completion
Attention/concentration problems	Hyperactivity
Oppositionality	Problems following directions
Learning problems	Social problems
Motor or coordination problems	Behavior or emotional problems

TREATMENT HISTORY:

Circle all services your child ***currently*** receives, where and how often:

	Where:	When:
Case management/county services	_____	
Individual psychotherapy	_____	
Family therapy	_____	
Psychiatry/Med Management	_____	
Occupational therapy	_____	
Speech therapy	_____	
Physical therapy	_____	
Day treatment	_____	
Tutoring	_____	

Circle all PAST services your child has received:

	Where:	When:
Case management/county services	_____	
Individual psychotherapy	_____	
Family therapy	_____	
Psychiatry/Med Management	_____	
Occupational therapy	_____	

Speech therapy _____
Physical therapy _____
Day treatment _____
Tutoring _____

Has your child had a psychological, psychoeducational or neuropsychological assessment in the past? If so, please list dates and findings:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Has the child received inpatient hospitalization for psychiatric reasons? YES NO
If yes, when and where: _____
_____
_____
_____

CURRENT MEDICAL STATUS

Primary Care Provider: _____
Location: _____

Height: _____ Weight: _____

Is your child currently within normal limits for height and weight for his/her age?
YES NO

Does your child currently have a medical condition for which they are being treated?

_____
_____
_____

List all past surgeries with dates and location:

_____
_____
_____
_____

Hospitalizations:

_____
_____
_____

Has the child had any of the following:

- Poor growth
- Facial or other physical abnormalities
- Physical disability
- Vision difficulties
- Skin problems
- Muscle problems
- Repeated ear infections
- Hearing difficulties
- Tubes placed
- Failure to thrive
- Cognitive problems
- Delays in motor development
- Small head circumference
- Tonsillectomy/adenoidectomy
- Gastroesophageal reflex
- Allergies: _____
- Feeding problems

Are there current health concerns for your child?

_____
_____
_____
_____
_____
_____
_____

Current medications taken: (name and dose, all prescribed)

_____
_____
_____
_____

_____

Do you feel that medications are effective? YES NO
Is your child responsible for taking his or her own medications? YES NO

NEUROLOGICAL HISTORY

Has your child ever received a brain scan such as a CT scan or MRI, x-ray, EEG?
If yes, please describe, with dates, locations, and findings:

_____
_____
_____
_____
_____

Check all that apply:

- ○ Birth injury
- ○ Cerebral palsy
- ○ Seizures
- ○ Encephalitis
- ○ Endocrine problems
- ○ Brain tumor
- ○ Hydrocephalus
- ○ Skull fracture or concussion
- ○ Metabolic disorder
- ○ Genetic disorder
- ○ Meningitis
- ○ Tuberous sclerosis
- ○ Multiple sclerosis (MS)
- ○ Near drowning
- ○ Choking or strangulation

Age of diagnosis:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Has your child ever had a seizure? YES NO

Check subtype:

- ○ Tonic (stiffening)
- ○ Clonic (jerking)
- ○ Myoclonic
- ○ Absence (staring)
- ○ Atonic (drops or loses tone)
- ○ Infantile spasm (febrile)

Provide details of child's seizures, including whether left or right side, region (e.g., frontal, occipital), when they occur, how often, whether your child recalls the seizures, if there is loss of bladder/bowel control, etc.

_____
_____
_____
_____
_____

Does your child have headaches? YES NO

If yes, please answer the following questions below. If not, skip to next page.

How often do they occur: Daily Weekly Monthly
Time of day they begin: Morning Afternoon Evening
How long do they last? 10-15 min. 30 min. 1 hour or more
Pain severity is: mild 1 2 3 4 severe
Warning that headaches will occur (e.g., aura) YES NO
Vomiting? YES NO
What interventions are used?

_____

Has the child had a head injury or concussion? YES NO
If yes, was there loss of consciousness? YES NO

_____

Please list post-concussive symptoms: (e.g., headaches, black-outs, irritability, mood changes, personality changes, learning difficulties):

_____
_____
_____

Was the child seen in the ER? YES NO

Were neurological scans completed? YES NO

Is there a neurologist following your child? YES NO
If yes, list provider: _____

List other agencies or organizations involved in your child's care currently:

_____
_____
_____
_____

Please list any additional concerns that were not reported in this form:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____