RANDALL CHILDREN'S HOSPITAL
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Neuropsychology Services

# PEDIATRIC QUESTIONNAIRE

***Parent/Guardian:*** *Please complete this questionnaire and bring it with you to your first appointment with Dr. Aimée Gerrard-Morris / Dr. Sunita Nijhawan / Dr. Corey Anderson.*

## IDENTIFYING INFORMATION

Child's Name: _____

Date of Birth: _____ Age:_____ Sex: __M __F __ Non-binary

Child's Legal Guardian(s): _____

Home Address: _____
(street, city, state, zip code)

Home Phone: (  )_____ Work: (  )_____ Cell: (  )_____

School Name:_____

Grade in School:_____ Type of Class: _____

Person Completing Form: _____ Relationship:_____

## PURPOSE OF EVALUATION

Who referred you for this evaluation?

Please describe your concerns about your child:

## PREGNANCY, BIRTH HISTORY & EARLY DEVELOPMENT

**Please describe any illnesses or complications during the pregnancy with the child:** _____
_____

**During pregnancy, did the child's mother:** ___smoke ___drink alcohol ___take drugs

**Please list all medications taken during pregnancy:** _____

**Was the child born:** ❑ Full Term (37-42 weeks) ❑ Premature ____weeks

**Delivery method:** ❑ Vaginal ❑ Cesarean **Child's birth weight:** _____

**Please describe any complications during the delivery:** _____
_____

**Did your child require any special care shortly after birth or during the first few weeks of life? If yes, describe:** _____
_____

**At what age did your child:**
Walk without support _____ Speak in single words _____ Combine 2-3 words _____

**Do you feel your child's early development (speech/language, motor skills, social skills, self-help skills) was delayed in any way?** _____
_____

## MEDICAL HISTORY

**Please check and describe the medical conditions that your child has or has had in the past (include age of diagnosis/incident).**

- ❑ Eating/feeding problems _____
- ❑ Disease _____
- ❑ Genetic disorder _____
- ❑ Hospitalization _____
- ❑ Surgery _____
- ❑ Head injury _____
- ❑ Loss of consciousness _____
- ❑ Seizure/Epilepsy _____
- ❑ Neurological disorder _____
- ❑ Frequent headaches _____
- ❑ Abuse/neglect _____
- ❑ Hearing problems _____
- ❑ Vision problems _____
- ❑ Toileting problems _____
- ❑ Sleeping problems _____
- ❑ Other medical problems _____

**Please list the medications your child takes:** _____

_____

**Child's primary care physician:** _____
**Address:** _____ **Phone:** _____

**Please list other medical professionals or therapists involved in your child's care (e.g., doctors, psychologist, social worker, counselor, tutor, speech/language therapist, OT, PT).**

_____

## FAMILY HISTORY

**Parent 1 Name:** _____ **Age:** _____
**Highest level of education completed:** _____ **Current occupation:** _____

**Parent 2 Name:** _____ **Age:** _____
**Highest level of education completed:** _____ **Current occupation:** _____

**Parents are:**
- ❑ Married
- ❑ Separated
- ❑ Divorced
- ❑ Unmarried, living together
- ❑ Unmarried, not living together
- ❑ Widowed

**Child is:**
- ❑ Biological child
- ❑ Adopted (at age ___)
- ❑ Fostered (at age ___)
- ❑ Other (describe):_____
  _____

**Please list all persons who currently live with the child.**

| Name | Relationship | Age |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Please check and indicate family members who have/had any of the following difficulties:**

| | Relationship of person(s) to child |
|---|---|
| ❑ Trouble learning to read/spell | _____ |
| ❑ Trouble learning math | _____ |
| ❑ Speech/language problems | _____ |
| ❑ Repeated grades | _____ |
| ❑ Inattention/hyperactivity | _____ |
| ❑ Intellectual or developmental disability | _____ |
| ❑ Autism/Asperger's Disorder | _____ |
| ❑ Anxiety/depression | _____ |
| ❑ Other mental health problems | _____ |
| ❑ Neurological disorder (e.g., seizures, stroke) | _____ |
| ❑ Other (describe) | _____ |

## SCHOOL HISTORY

**Does your child receive special education services for any of the following?**

| | Age when service began |
|---|---|
| ❑ Early intervention | _____ |
| ❑ Learning disability | _____ |
| ❑ Intellectual or Developmental disability | _____ |
| ❑ Autism | _____ |
| ❑ Communication disorder | _____ |
| ❑ Emotional disturbance | _____ |
| ❑ Multiple handicap | _____ |
| ❑ Hearing impairment | _____ |
| ❑ Visual impairment | _____ |
| ❑ Traumatic Brain Injury | _____ |
| ❑ Other health impairment | _____ |
| ❑ Orthopedic impairment | _____ |

**Please check the services your child has or has had in the past:**

| | Age when service began |
|---|---|
| ❑ Speech/language therapy | _____ |
| ❑ Physical therapy | _____ |
| ❑ Occupational therapy | _____ |
| ❑ Academic tutoring | _____ |
| ❑ Counseling | _____ |
| ❑ Other (describe) | _____ |

| | YES | NO |
|---|---|---|
| **Has your child repeated a grade?** | ❑ | ❑ |
| If yes, which grade_____? | | |
| **Has your child completed a school evaluation by a psychologist?** | ❑ | ❑ |
| If yes, indicate date(s): _____ | | |
| **Does your child receive special accommodations in school?** | ❑ | ❑ |
| If yes, indicate annual review date: _____ | | |
| **Has your child had excessive school absences?** | ❑ | ❑ |
| If yes, explain:_____ | | |

*Thank you for taking the time to complete this questionnaire. I look forward to seeing you on your appointment date.*

**Parent/Guardian Name (print): _____**

**Parent/Guardian Signature: _____Date: _____**