Psychological & Neuropsychological Information
CHILD & ADOLESCENT EDITION

Instruction:
This questionnaire is designed to help you assist us in collecting information which will help us in identifying elements which can be important in addressing the problems. Helping you resolve problems quickly and effectively is important to us. This information helps us in this effort. Please be as honest and complete as possible so when we meet individually we can focus on the issues of immediate concern to you. Please print clearly. Thank you!

THIS QUESTIONNAIRE WAS COMPLETED BY:_____ Relationship:_____

Child's Name:_____ Birth date:_____

Social Security Number:_____ Age:_____

Address:_____

Phone: _____ Other Siblings & Their Living Situation _____

_____

Biological Parent's Marital Status:_____ If parents are divorced or separated, what are the custody arrangements & visitation?_____

Legal Guardian/s:_____

PLEASE NOTE: Non-custodial parents can, as a general rule, have access to the clinical records of a child who is in counseling. We also try to involve both parents in the treatment process if appropriate. Please discuss this with your counselor if this is a concern.
Who referred you?_____

What was the purpose of the referral (Note reports and information requested by the referral source.)?_____

_____

What problems do you feel need to be addressed?_____

_____

_____

What problems are your child currently experiencing & when did your child start having the problems:

Problem	Onset

Please state any specific questions you or the referring source has which need to be answered by this evaluation:

_____

_____

_____

	What are the child's strengths?
1	
2	
3	
4	

	What are the child's weaknesses?
1	
2	
3	
4	

Background History:

At what point did the child begin to experience problems related to the current concern? Please note any events or changes that occurred.

What emotional or psychological problems has the child had in the past?

Has the child or any family member been hospitalized for mental or emotional problems (If yes, state where and when.)?

List any other counseling the child or your family have had in the past?

How do you and/or your child feel about seeking and obtaining counseling or therapy?

How does the child cope with stress and/or depression?

Has the child had psychological testing in the past? Please state where and when.

Please check items that the child is or has experienced:

CURRENT	PAST		CURRENT	PAST	
☐	☐	severe depression	☐	☐	thoughts of harming others
☐	☐	severe mood swings	☐	☐	memory problems
☐	☐	hallucinations	☐	☐	worrying
☐	☐	paranoia	☐	☐	nightmares
☐	☐	explosive anger	☐	☐	learning disorders
☐	☐	suicidal thoughts	☐	☐	emotional or physical abuse
☐	☐	suicide plans	☐	☐	unrealistic fears
☐	☐	suicide attempt/s	☐	☐	panic attacks
☐	☐	sexual acting out	☐	☐	seizures
☐	☐	rage episodes	☐	☐	tics
☐	☐	stealing	☐	☐	take medication for nerves
☐	☐	thoughts that disturb sleep	☐	☐	physical problems when under stress

Birth History:

Where was the child born?

Did the mother take any medications during pregnancy? ☐ Yes ☐ No

If YES, explain:

Did the mother smoke during pregnancy? ☐ Yes ☐ No

If YES, explain:

Did the mother drink alcohol during pregnancy? ☐ Yes ☐ No

If YES, explain:_____

Did the mother use drugs during pregnancy? ☐ Yes ☐ No

If YES, explain:_____

Were there any problems during pregnancy? ☐ Yes ☐ No

If YES, explain:_____

_____

Were there any problems with the delivery? ☐ Yes ☐ No

If YES, explain:_____

Birth Weight:_____ Was the birth premature? ☐ Yes ☐ No

If YES, how many weeks:_____

Were there any birth defects or complications after delivery? ☐ Yes ☐ No

If YES, explain:_____

DEVELOPMENTAL HISTORY:

What forms of discipline have been and are used in the family?_____

_____

Developmental Milestones

For each of the following, note the age at which your child began the activity:

turning over:_____

crawling:_____

standing:_____

walking with assistance:_____

walking without assistance:_____

running:_____

first word:_____

two to three word sentences:_____

count to 10:_____

say the alphabet_____

name colors:_____

add numbers:_____

subtract numbers:_____

identify letters:_____

spell simple 3 letter words:_____

identify geometric shapes:_____

identify difference in sizes:_____

balance on one leg:_____

jump at least 3 inches high:_____

pretend play: _____

playing with others: _____

print name: _____

Has the child ever been abused or neglected? Verbally: ☐ Yes ☐ No If YES, by whom:_____

Physically: ☐ Yes ☐ No If so, by whom:_____Sexually: ☐ Yes ☐ No If YES, by whom:_____

Children's Problem Checklist

Yes	No	ACADEMIC
☐	☐	Poor reading comprehension
☐	☐	Difficulty with phonics
☐	☐	Letters and number reversed
☐	☐	Inaccurate reading
☐	☐	Difficulty reading aloud
☐	☐	Poor handwriting
☐	☐	Inaccurate copying (from blackboard or at desk)
☐	☐	Difficulty with math computational skills
☐	☐	Difficulty working independently
☐	☐	Sloppy work habits
☐	☐	Difficulty with spelling
☐	☐	Difficulties with verbal expression
☐	☐	Difficulties with written expression
☐	☐	Difficulties with grammatical skills
☐	☐	Poor organizational skills

- ☐ ☐ Poor planning skills
- ☐ ☐ Incomplete projects
- ☐ ☐ Difficulty following verbal instructions
- ☐ ☐ Difficulty following written instructions
- ☐ ☐ Chronic procrastination
- ☐ ☐ Disturbs other students
- ☐ ☐ Tends to be distracted from listening, especially when first spoken to
- ☐ ☐ Dislikes reading
- ☐ ☐ Negative attitude toward school
- ☐ ☐ Unwillingness to complete homework accurately
- ☐ ☐ Difficulty keeping up with class
- ☐ ☐ Excessive sensitivity to failure
- ☐ ☐ Resistance to accepting help

Yes No BEHAVIOR

- ☐ ☐ Short attention span
- ☐ ☐ Difficulty following directions
- ☐ ☐ Overactive
- ☐ ☐ Impulsive
- ☐ ☐ Fidgety
- ☐ ☐ Distractible
- ☐ ☐ Accident-prone
- ☐ ☐ Forgetful
- ☐ ☐ Daydreams
- ☐ ☐ Slow in completing tasks
- ☐ ☐ Excitable
- ☐ ☐ Unpredictable
- ☐ ☐ Immature behaviors
- ☐ ☐ Impatience
- ☐ ☐ Low tolerance for frustration
- ☐ ☐ Difficulty accepting responsibility
- ☐ ☐ Low self-confidence
- ☐ ☐ Delusions (persecution, grandeur)
- ☐ ☐ Sensory distortion
- ☐ ☐ Withdrawal or social isolation
- ☐ ☐ Tantrums
- ☐ ☐ Superstitious activities
- ☐ ☐ Extreme mood change
- ☐ ☐ Excessive fantasizing
- ☐ ☐ Phobic reactions
- ☐ ☐ Fixations
- ☐ ☐ Suicidal tendencies
- ☐ ☐ Bed-wetting (in older children)
- ☐ ☐ Incontinence (in older children)
- ☐ ☐ Repeated stomachaches
- ☐ ☐ Sleep disturbances
- ☐ ☐ Chronic lying
- ☐ ☐ Depression
- ☐ ☐ Attempts to control self or others
- ☐ ☐ Unwillingness to communicate
- ☐ ☐ Substance abuse
- ☐ ☐ Explosive anger
- ☐ ☐ Chronic bullying

Yes No MOTOR SKILLS

- ☐ ☐ Gross-motor coordination deficits
- ☐ ☐ Fine-motor coordination deficits (drawing/handwriting, etc.)
- ☐ ☐ Clumsiness
- ☐ ☐ Awkwardness
- ☐ ☐ Poor balance
- ☐ ☐ Right/Left Confusion
- ☐ ☐ Pronounced physical immaturity
- ☐ ☐ Delayed development
- ☐ ☐ Reflex asymmetry
- ☐ ☐ Poor and immature drawings

Yes No PERCEPTUAL SKILLS

- ☐ ☐ Auditory memory deficits (forgets what is heard)
- ☐ ☐ Auditory discrimination deficits (cannot hear the difference between sounds)
- ☐ ☐ Visual memory deficits (cannot see the difference between letters
- ☐ ☐ Letter reversals
- ☐ ☐ Figure-ground deficits (cannot perceive spatial relationships)
- ☐ ☐ Poor memory for designs

Yes No MEMORY & COGNITION

- ☐ ☐ Poor organization of ideas
- ☐ ☐ Difficulty thinking abstractly (understanding ideas and concepts)

Yes No VISUAL/HEARING/SPEECH IMPAIRMENT

- ☐ ☐ Tone deaf
- ☐ ☐ Poor articulation
- ☐ ☐ Eye-control irregularities

Yes No LANGUAGE (AUDITORY PROCESSING)

- ☐ ☐ Difficulty paying attention to auditory stimuli
- ☐ ☐ Difficulty discriminating sound versus no sound
- ☐ ☐ Difficulty locating where sound is coming from
- ☐ ☐ Difficulty discriminating different sounds
- ☐ ☐ Difficulty distinguishing primary sounds from background sound
- ☐ ☐ Difficulty associating sounds with the source of the sound
- ☐ ☐ Difficulty filtering out extraneous sounds
- ☐ ☐ Difficulty sequencing ideas
- ☐ ☐ Oral reversal (e.g., emeny instead of enemy)
- ☐ ☐ Circumlocutions (imprecise, roundabout communication. For example, "that place down where they sell the thingamajig.")

Yes No LANGUAGE (LINGUISTIC PROCESSING)

- ☐ ☐ Poor grammar
- ☐ ☐ Wrong verb tenses
- ☐ ☐ Use of only broad meanings for words
- ☐ ☐ Lack of understanding of subtle meanings or differences between words
- ☐ ☐ Lack of understanding spatial prepositions (beneath/beside)
- ☐ ☐ Difficulty understanding words denoting time and space (before/here)
- ☐ ☐ Difficulty understanding comparatives and superlatives (bigger/biggest, far/near)

Yes No LANGUAGE (COGNITIVE PROCESSING)
- ☐ ☐ Difficulty following oral directions
- ☐ ☐ Difficulty expressing thoughts and information
- ☐ ☐ Difficulty classifying
- ☐ ☐ Difficulty putting events in sequence or order
- ☐ ☐ Difficulty making comparisons
- ☐ ☐ Difficulty understanding or expressing the moral of a story
- ☐ ☐ Difficulty predicting the outcome of a story or event
- ☐ ☐ Difficulty differentiating between fact and fiction
- ☐ ☐ Difficulty remembering and expressing facts
- ☐ ☐ Difficulty drawing conclusions
- ☐ ☐ Difficulty relating to cause and effect

Yes No LANGUAGE (SOCIAL PROBLEMS)
- ☐ ☐ Difficulty understanding subtle verbal and nonverbal cues
- ☐ ☐ Excessive talking
- ☐ ☐ Talking at inappropriate times

Yes No LANGUAGE (WRITTEN LANGUAGE)
- ☐ ☐ Difficulty expressing in written words what is known (dysgraphia)
- ☐ ☐ Difficulty copying letters, numbers, or words
- ☐ ☐ Difficulty writing spontaneously or from dictation
- ☐ ☐ Difficulty drawing (but no problem copying)
- ☐ ☐ Difficulty organizing thoughts for writing
- ☐ ☐ Difficulty writing with good syntax (but no difficulty with spoken grammar)

Yes No LANGUAGE (APHASIA/DYSPHASIA)
- ☐ ☐ Difficulty making facial motor movements to produce sounds (dyspraxia)
- ☐ ☐ Difficulty imitating sounds
- ☐ ☐ Difficulty remembering words (but can repeat them)
- ☐ ☐ Difficulty formulating sentences (but can use single words)
- ☐ ☐ Difficulty naming common objects
- ☐ ☐ Difficulty recalling a specific word
- ☐ ☐ Substitutions (rattle for beetle)
- ☐ ☐ Distorted body image (as reflected in drawings)
- ☐ ☐ Difficulty copying designs
- ☐ ☐ Difficulty with directional concepts (right/left)
- ☐ ☐ Poor attention span
- ☐ ☐ Poor coordination
- ☐ ☐ Clumsiness
- ☐ ☐ Hyperactivity
- ☐ ☐ Emotional disturbances
- ☐ ☐ Difficulty recognizing common objects by touch

Yes No READING
- ☐ ☐ Visual Impairment (Inability to see with acuity)
- ☐ ☐ Visual tracking deficits (inability to see words word, phrases, etc. because of eye movement)
- ☐ ☐ Visual tracking (loss of place when reading)
- ☐ ☐ Visual discrimination deficit (inability to remember the visual shape of letters or words)
- ☐ ☐ Visual discrimination deficit (inability to associate shapes with letters, sounds, etc.)
- ☐ ☐ Visual association deficit (inability to associate visual configuration or meaning of the word with what is seen)
- ☐ ☐ Auditory association deficit (inability to associate sound or meaning of the word with what is heard)
- ☐ ☐ Phonics and/or blending deficit (inability to sound words out)
- ☐ ☐ Auditory impairment (inability to hear certain sounds, especially in the high-frequency range)
- ☐ ☐ Auditory discrimination deficit (inability to hear the difference between sounds such as the short i and the short e) [the key to decoding]
- ☐ ☐ Auditory memory deficit (inability to remember the sounds that letters make)

Please list family members, and fill in current age, and strengths.

Family Member		Current Age	Strengths
Child			
FATHER			
MOTHER			
BROTHERS & SISTERS			

Parent's Employment:

Father's Position	Employer	Length of Employment
Mother's Position	Employer	Length of Employment

Changes/Moves During Childhood Years: _____

_____

Please note any divorces, remarriages, or other major changes in your family when you were a child?

_____

What types of family problems have or do exist? _____

_____

The Child's Peer Group/s:

Past: _____

Current: _____

Hobbies/Activities: Past: _____

Current: _____

Favorite Movies: Past: _____

Current: _____

Favorite Music: Past: _____

Current: _____

Family Financial issues: Past: _____

Current: _____

Religion/Belief System: _____

Cultural Questionnaire

What is the child's ethnic background? _____

How would you describe the child's cultural orientation? _____

What holidays have or does the family celebrate? _____

Are there special items, toys, movies, etc. that the child values? Please explain. _____

_____

Educational History:

Education:

Current Grade: _____

GPA History

	GRADE (Year In School)											
	1	2	3	4	5	6	7	8	9	10	11	12
AVERAGE GPA												

School Performance

Current	Past	Problems	Current	Past	Problems
☐	☐	truancy	☐	☐	acting out behavior
☐	☐	absences because of illness	☐	☐	difficulty learning
☐	☐	absences (not related to illness)	☐	☐	emotional problems
☐	☐	fights with student	☐	☐	social withdrawal
☐	☐	oppositional behavior towards teachers	☐	☐	suicidal thoughts or gestures
☐	☐	drug and/or alcohol use	☐	☐	Other (specify):

Current	Past	Classes Where Child Has Problems	Current	Past	Classes of Special Interest to Child
☐	☐	English	☐	☐	English
☐	☐	Science	☐	☐	Science
☐	☐	Social Studies	☐	☐	Social Studies
☐	☐	Music	☐	☐	Music
☐	☐	Art	☐	☐	Art
☐	☐	Math	☐	☐	Math
☐	☐	Physical Education	☐	☐	Physical Education
☐	☐	Health	☐	☐	Health
☐	☐	Other (specify):_____	☐	☐	Other (specify):_____

Current	Past	Extracurricular Activities	Current	Past	Extracurricular Activities
☐	☐	School Club:_____	☐	☐	Football
☐	☐	Track	☐	☐	Soccer
☐	☐	Basketball	☐	☐	Student Assistant
☐	☐	Cheerleading	☐	☐	D/A Prevention Activities
☐	☐	Baseball	☐	☐	Other (specify):_____

History of Remedial Services (tutoring, speech therapy, etc.):

Current Career Goals:_____

Medical History:

Who is the child's physician?_____

When was his/her last medical examination?_____ How frequently does the child see the physician?_____

Current medical issues:_____

Current medications the child is taking:_____

_____

_____

_____

Medication History:

Please list medications and reactions.

Medication	Age Started	Age Discontinued	Effect

Medication	Age Started	Age Discontinued	Effect

Past medical problems (please check those that apply):

- ☐ Measles
- ☐ German measles
- ☐ Mumps
- ☐ Chicken pox
- ☐ Whooping cough
- ☐ Diphtheria
- ☐ Scarlet fever
- ☐ Rheumatic fever
- ☐ Malaria
- ☐ Headaches
- ☐ Migraines
- ☐ Fatigue
- ☐ High fever
- ☐ Meningitis
- ☐ Encephalitis
- ☐ Epilepsy (seizures)
- ☐ Coma
- ☐ Tuberculosis
- ☐ Polio
- ☐ Fainting spells
- ☐ High blood pressure
- ☐ Stroke
- ☐ Chest pain
- ☐ Heart disease
- ☐ Heart attack
- ☐ Bone or joint disease
- ☐ Muscle disease
- ☐ Bleeding problems
- ☐ Anemia
- ☐ STD
- ☐ HIV infection
- ☐ Sunstroke
- ☐ Near drowning
- ☐ Altitude sickness
- ☐ Electrical shock
- ☐ Injury to the head
- ☐ Tumor
- ☐ Cancer
- ☐ Paralysis
- ☐ Eye or vision problems
- ☐ Ear or hearing problems
- ☐ Loss of sense of touch
- ☐ Tingling/ numbness feelings
- ☐ Loss of sense of smell
- ☐ Loss of sense of taste
- ☐ Difficulty with balance
- ☐ Eczema or hives
- ☐ Allergies
- ☐ Pulmonary (lung) disease
- ☐ Jaundice or hepatitis
- ☐ Kidney problems
- ☐ Dialysis
- ☐ Parkinson's disease
- ☐ Huntington's disease
- ☐ Multiple sclerosis
- ☐ Lupus
- ☐ Electric shock therapy
- ☐ Lead poisoning
- ☐ Exposure to toxins
- ☐ Exposure to pesticides
- ☐ Carbon Monoxide poisoning
- ☐ Nutritional deficiencies
- ☐ Alcoholism
- ☐ Broken bones
- ☐ Hospitalizations
- ☐ Operations
- ☐ Hypothyroidism (low)
- ☐ Hyperthyroidism (high)
- ☐ Diabetes
- ☐ Hypoglycemia (low)
- ☐ Endocrine disorders
- ☐ Menstrual irregularity
- ☐ Gynecological problems
- ☐ Miscarriages
- ☐ Abortions
- ☐ Back injuries
- ☐ Other (specify):_____

Chemical sensitivities or reaction to medications:_____

_____

Has the child had prolonged use or exposure to solvents/toxic chemicals:_____

Allergies:_____

How much sleep does the child get per night?_____ Is it restful sleep?_____

Family history of medical problems:_____

For Girls

Current or past menstrual cycle problems:_____

Pregnancies:_____

Head Traumas:

Please list head injuries the child has had, and provide details if possible.

DATE	EVENT	COMMENTS

Nutritional Information:

Does the child eat breakfast? ☐ Yes ☐ No If yes, what does breakfast usually consist of? _____

_____

Does the child eat lunch? ☐ Yes ☐ No If yes, what does lunch usually consist of? _____

_____

Does the child eat dinner? ☐ Yes ☐ No If yes, what does dinner usually consist of? _____

_____

Has the child recently loss or gained weight? ☐ Yes ☐ No If yes, indicate the weight before, the weight now, and the length of time the weight change occurs? _____

Please check the types of ways that the child has attempted to lose weight.

☐ fasting ☐ exercise ☐ dieting (specify types of diets) _____

Has the child ever vomited after a meal to get rid of the food he/she just ate? ☐ Yes ☐ No

Has the child ever abused laxatives to lose weight or get rid of the food he/she just ate? ☐ Yes ☐ No

Does your child feel he/she is fat? ☐ Yes ☐ No Do you feel that the child has an eating disorder? ☐ Yes ☐ No

How much water does the child drink per day? _____

Alcohol/Drug History:

In the table below, please list drugs (including alcohol) the child has taken (Please use back of form if necessary.). Please complete all columns.

Drug	Admission (oral, IV, smoke)	First Use	Last Use	Frequency	Heaviest Use	Comments
Alcohol						
Tobacco						
Marijuana						
Amphetamines						
Cocaine						
Sniffing Glue						
LSD						
Mushrooms						
Other:						

Is there any family history of problems with alcohol or drugs? Please describe. _____

_____

If recovering, please describe the child's recovery program and any prior treatment: _____

_____

Problem History:

Does the child tend to have anger outbursts that feel like you can not control them? ☐ Yes ☐ No

Does the child cope with stress by eating? ☐ Yes ☐ No

Does the child tend to obsess about problems to the point that it interferes with other tasks? ☐ Yes ☐ No

Does the child tend to have nervous habits like picking at sores or biting finger nails? ☐ Yes ☐ No

Three Wishes:

If you had three wishes for the child, what would they be?_____

_____

_____

Legal History:

Is the child currently involved with the court or in legal difficulties? ☐ Yes ☐ No

If YES, explain & give name, address, and phone number of the child's attorney:_____

_____

_____

_____

Do you foresee any reason that the psychological report will be requested by the court?_____If so, please explain.___

_____

_____

_____

Please list any criminal charges, divorces, bankruptcies, or other legal involvements.

DATE	EVENT	COMMENTS

DAILY LIVING FUNCTION

Living Situation:
Place:
Others in the home:
Primary Caregiver:
Current Allowance:
Hygiene & Self-Care (Note frequency and any problems in these areas)
brushing teeth:
floss:
bathe:
dressing:
first aid:
bowel movements:
continence:
mobility:
grooming:
remembering medications:
eating:
exercise:
sleep:
ways of coping with stress
Socialization
interaction with mother:
interaction with father:
interaction with stepparent:
interaction with siblings:
interaction with teachers:
interaction with strangers:
interaction with friends:
asking questions:
coping with crowds:
talking on telephone:
coping with criticism:
trusting others:

puts other peoples needs first:
taking responsibility for own actions:
exposure to domestic violence:
inappropriate sexual behaviors:
shopping:
recreation:
problems:
School & Learning (if in school)
home school or public school:
attention in classroom:
behavior in classroom:
number of times suspended:
cause of suspension:
number of referrals:
cause of referrals:
works independently:
interaction with teachers:
taking direction:
interaction with classmates:
organization:
absences:
punctuality:
problems in school:

In the space below, note what a normal day schedule is for the child and areas of problems.

WEEKEND

WEEK DAYS

Please return this Questionnaire to Dr. Rory Richardson as soon as possible. Thank you!