

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

- severe depression
- severe mood swings
- hallucinations
- paranoia
- explosive anger
- suicidal thoughts
- suicide plans
- suicide attempt/s
- sexual acting out
- rage episodes
- stealing
- thoughts that disturb sleep

CURRENT PAST

- thoughts of harming others
- memory problems
- worrying
- nightmares
- learning disorders
- emotional or physical abuse
- unrealistic fears
- panic attacks
- seizures
- tics
- take medication for nerves
- 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: _____

add numbers: _____

crawling: _____

subtract numbers: _____

standing: _____

identify letters: _____

walking with assistance: _____

spell simple 3 letter words: _____

walking without assistance: _____

identify geometric shapes: _____

running: _____

identify difference in sizes: _____

first word: _____

balance on one leg: _____

two to three word sentences: _____

jump at least 3 inches high: _____

count to 10: _____

pretend play: _____

say the alphabet _____

playing with others: _____

name colors: _____

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			

School Performance

<p>Current</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Past</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Problems</p> truancy absences because of illness absences (not related to illness) fights with student oppositional behavior towards teachers drug and/or alcohol use	<p>Current</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Past</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Problems</p> acting out behavior difficulty learning emotional problems social withdrawal suicidal thoughts or gestures Other (specify): _____
<p>Current</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Past</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Classes Where Child Has Problems</p> English Science Social Studies Music Art Math Physical Education Health Other (specify): _____	<p>Current</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Past</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Classes of Special Interest to Child</p> English Science Social Studies Music Art Math Physical Education Health Other (specify): _____
<p>Current</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Past</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Extracurricular Activities</p> School Club: _____ Track Basketball Cheerleading Baseball	<p>Current</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Past</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Extracurricular Activities</p> Football Soccer Student Assistant D/A Prevention Activities 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):

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

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:
copng with crowds:
talking on telephone:
copng with criticism:
trusting others:

puts other peoples needs first:
taking responsibility for own actions:
exposure to domestic violence:
inappropriate sexual behaviors:
shopping:
recreation:
problems:
<i>School & Learning (if in school)</i>
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!