KAREN BURK PAULL, PHD
CLEVELAND CHILD NEUROPSYCHOLOGY SERVICES, LLC
YOUNG ADULT BACKGROUND QUESTIONNAIRE
NEUROPSYCHOLOGICAL ASSESSMENT

Client Name:_____ Date of Birth: _____ □Male □Female

Home address: _____ City _____

State _____ Zip Code _____ Home phone number: _____

Cell phone: _____ Email: _____

What are your living arrangements? □College dorm □Off-campus apartment

□ At home with biological parent(s) □At home with adoptive parent(s)

□Other _____

Primary language: _____ Secondary language: _____

Are you □ Right handed □Left handed □Mixed handed

Parent Name #1: _____

Home address: _____

City _____ State _____ Zip Code _____

Alternate phone numbers (w): _____ (c): _____

Email address _____

Marital Status: □Married □Never married □Separated □Divorced □Widowed

Parent Name #2: _____

Home address: _____

City _____ State _____ Zip Code _____

Alternate phone numbers (w): _____ (c): _____

Email address _____

Marital Status: □Married □Never married □Separated □Divorced □Widowed

Reason for referral: Please explain what your main concerns are right now and the reasons you are seeking neuropsychological evaluation:_____

_____

_____

_____

_____

When did these concerns first emerge? _____

Have you ever been evaluated before for these concerns? □Yes □No

If yes, what type(s) of evaluation (speech/language, psychological, neuropsychological) and when?:_____

_____

Please describe your strengths: _____

_____

_____

_____

Medical History:

Were you born: □Early (weeks?_____) □On time □Late (weeks?_____)

Were you born via: □vaginal delivery □caesarean section

Please describe any concerns during the pregnancy, labor, or delivery: _____

_____

_____

Please indicate which of the following were used/taken during your mother's pregnancy with you: □alcohol □prescription medications □Over-the-counter medications □drugs (e.g., cocaine, heroine, marijuana) □tobacco

Please describe your condition at birth: _____

Did you have: □ jaundice □Rh problems □other _____

Weight at birth: _____ How long did you stay in the hospital? _____

Please indicate whether you have had the following:

	Age	
□Frequent ear infections	_____	
□Vision problems	_____	glasses prescribed? _____
□Serious illness(es)	_____	please specify: _____
□Hospitalization(s)	_____	when/for what?:_____
□Surgery	_____	please specify: _____
□Head injury (TBI, concussion)	_____	
□ Seizures/convulsions	_____	
□ Tics/body twitches	_____	please specify: _____
□ Staring spells/trances	_____	please specify: _____
□Genetic syndrome	_____	please specify: _____
□ Other medical concerns/ medical condition	_____	please specify: _____

Please list all medications you currently take: _____

_____

Who is the prescribing physician? _____

Please indicate any special services you receive at this time: (e.g., tutoring, counseling)

_____

Developmental History:

Please indicate the following, to the best of your knowledge:

Activity	Age	Earlier than peers	Same as peers	Later than peers
Smiling		□	□	□
Pointing		□	□	□
First word/sign		□	□	□
2 words/signs together		□	□	□
Used complete sentences		□	□	□

Activity	Age	Earlier than peers	Same as peers	Later than peers
Rolled over		□	□	□
Sat up		□	□	□
First steps		□	□	□
Toileting-days		□	□	□
Toileting-nights		□	□	□

Please indicate areas of development in which you have concerns:

□ Reading/spelling
□ Math
□ Written composition
□ Language
□ Completing and turning in schoolwork on time
□ Attention
□ Hyperactivity
□ Slow learner
□ Fine-motor (e.g., handwriting)
□ Gross-motor (e.g., walking, running)
□ Anxiety
□ Depression or withdrawal
□ Behavior
□ Social skills
□ Other psychological issues (_____)

Educational History:

Year in school _____ School Attending _____

When in grade school, middle school, or high school, did you have an IEP?

□Yes □No I f yes, what category were you qualified under? _____

Did you have a 504 plan? □Yes □No

Please indicate any concerns about your school functioning not yet reported above:

_____

_____

When did concerns at school first emerge? _____

Biological Family History:

Please indicate whether any family members (parents (P), siblings (S), aunts (A), uncles (U), grandparents (GP)) have struggled with the following:

	Whom?		Whom?		Whom?
□ Reading	_____	□ Attention	_____	□ Anxiety	_____
□ Math	_____	□ Hyperactivity	_____	□ Depression	_____

Biological Family History (continued):

Please indicate whether any family members (parents (P), siblings (S), aunts (A), uncles (U), grandparents (GP)) have struggled with the following:

	Whom?		Whom?		Whom?
□ Writing	_____	□ Slow learning	_____	□ Behavior problems	_____
□ Spelling	_____	□ Autism	_____	□ OCD	_____
□ Language (spoken/signed)	_____	□ Asperger's	_____	□ Other psychological issues (_____)	_____
□ Speech		□ Social skills	_____		

Anything else that you'd like to share that you're concerned about? _____

_____

_____