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CLEVELAND CHILD NEUROPSYCHOLOGY SERVICES, LLC
PEDIATRIC BACKGROUND QUESTIONNAIRE
NEUROPSYCHOLOGICAL ASSESSMENT

Child's Name:_____ Date of Birth: _____ ☐Boy ☐Girl ☐Non-binary

Child's home address: _____ City _____

State _____ Zip Code _____ Home phone number: _____

Referred by: _____

With whom does this child live? ☐Biological parent(s) ☐Adoptive parent(s)

☐Foster parent(s) ☐Biological grandparent(s) ☐Other _____

Has your child's hearing been checked? _____ At what age? _____

What were the results? _____

Is an amplification device used? (e.g., hearing aids, CI) _____

Primary language used in the home: _____ Secondary language: _____

Is this child ☐ Right handed ☐Left handed ☐Mixed handed ☐Not yet clear

Parent/Legal Guardian Name #1: _____

Home address: _____

City _____ State _____ Zip Code _____

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

Email address _____

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

Parent/Legal Guardian Name #2: _____

Home address: _____

City _____ State _____ Zip Code _____

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

Email address _____

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

Please list this child's brothers and sisters, their ages, and whether they live at home with this child.

Name	Age	Relationship	Lives at home with this child
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐

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

_____

_____

_____

_____

When did these concerns first emerge? _____

Has your child been evaluated before for these concerns? ☐Yes ☐No

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

_____

Please describe your child's strengths: _____

_____

_____

_____

Child's Medical History:

Was this child born: ☐Early (weeks?_____) ☐On time ☐Late (weeks?_____)

Was this child 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 pregnancy: ☐alcohol ☐prescription medications ☐Over-the-counter medications ☐drugs (e.g., cocaine, heroine, marijuana) ☐tobacco

Please describe the baby's condition at birth: _____

Did the baby have: ☐ jaundice ☐Rh problems ☐other _____

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

Please indicate whether your child has 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 your child currently takes: _____

_____

Who is the prescribing physician? _____

Please indicate any special services your child receives at this time outside of school: (e.g., speech therapy, occupational therapy, psychotherapy) _____

_____

Child's Developmental History:

Please indicate the following for your child

Activity	Age	Earlier than peers	Same as peers	Later than peers
Smiling		☐	☐	☐
Pointing		☐	☐	☐
First word/sign		☐	☐	☐
2 words/signs together		☐	☐	☐
Used complete sentences		☐	☐	☐
Rolled over		☐	☐	☐
Sat up		☐	☐	☐
First steps		☐	☐	☐
Toileting-days		☐	☐	☐
Toileting-nights		☐	☐	☐

Please indicate areas of your child's development in which you have concerns:

☐ Reading/spelling	☐ Attention	☐ Anxiety
☐ Math	☐ Hyperactivity	☐ Depression or withdrawal
☐ Written composition	☐ Slow learner	☐ Behavior
☐ Speech	☐ Fine-motor (e.g., handwriting)	☐ Social skills
☐ Spoken/signed language	☐ Gross-motor (e.g., walking, running)	☐ Other psychological issues (_____)

Child's Educational History:

Grade in school _____ School Attending _____

Does your child have an IEP? ☐Yes ☐No A 504 plan? ☐Yes ☐No

When was your child's most recent ETR? _____

Please indicate any concerns about your child's 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	_____
☐ Writing	_____	☐ Slow learning	_____	☐ Behavior problems	_____
☐ Spelling	_____	☐ Autism	_____	☐ OCD	_____
☐ Language	_____	☐ Social skills	_____	☐ Other psychological issues (_____)	
☐ Speech	_____				

Parents:

Father's Highest Level of Education _____ Occupation _____

Mother's Highest Level of Education _____ Occupation _____