MARVELOUS MINDS, INC
NEUROPSYCHOLOGICAL CHILD HISTORY

INSTRUCTIONS TO PARENT OR GUARDIAN: This form must be completed and returned to Marvelous Minds before your child's appointment. Please fill out the form to the best of your knowledge. If some questions do not apply to your child, write in NA. IF you need more space or wish to make additional comments, please do so on a separate sheet of paper and attach it to this form. Thank you.

Child's Name: _____ Date of Birth: _____

Parent's (1) Name: _____ Parent's (2) Name: _____

Home Address: _____

Telephone: (_____)_____ Email:_____

Telephone: (_____)_____ Email:_____

Secondary Home Address: _____

Secondary Telephone: (_____)_____Email:_____

Business Name & Address of Parent (1):

_____

Business Phone: (_____)_____

Business Name & Address of Parent (2): _____

Business Phone: (_____)_____

Pediatrician: _____ Phone #: (_____)_____

Other specialist: _____ Phone #: (_____)_____

Other specialist: _____ Phone #: (_____) _____

Other specialist: _____ Phone #: (_____) _____

School currently attending: _____ Grade: _____

Address: _____

Phone #: (_____)_____

Reason for consultation: _____

_____

_____

_____

Referred by: _____

Name of person filling out this form: _____

Relationship to the child: _____ Today's Date: _____

PREGNANCIES

Was the child adopted? ❑yes ❑no

Indicate the month(s) of your pregnancy that you experienced any of the following complaints:

Anemia _____ High blood pressure _____ Swollen ankles _____

Kidney disease _____ Heart disease _____ German Measles _____

Toxemia _____ Staining _____ Bleeding _____ Vomiting _____

Rh or other blood incompatibility: _____ Virus: _____

Specify any other diseases present: _____

List any threatened miscarriages or early contractions:_____

List any chronic illness(s) during your pregnancy such as diabetes, kidney infection, thyroid, epilepsy, etc.:

_____

List any other illnesses during pregnancy: _____

_____

Hospitalization (dates/where): _____

_____

Operations (dates/type): _____

_____

Injuries (dates/type): _____

What medications, if any, did you take during this pregnancy? _____

_____

Did you consume alcohol during this pregnancy? ❑yes ❑no If yes, how much and frequency:

_____

List any other complications: _____

_____

List all of your pregnancies in order, including the child to be seen at the clinic. If a pregnancy ended in miscarriage, state at which month. If you have had more than five pregnancies, list on back of this page.

Year	Name	Length of Pregnancy	Birth Weight	Sex	Complications

BIRTH HISTORY

Name of hospital: _____

Did you have a Cesarean Section? ❑yes ❑no If yes, why? _____

_____

How many hours from the first contraction to birth? _____

Were you given medication? ❑yes ❑no If yes, what kind? _____

Were you under anesthesia during childbirth? ❑yes ❑no If yes, what kind? _____

_____

Was labor induced? ❑yes ❑no If yes, why? _____

_____

How was labor induced? _____

Was the baby born head first? ❑yes ❑no Were forceps used? ❑yes ❑no

Did the baby have any bruises? ❑yes ❑no

Did the baby have any birthmarks? ❑es ❑no If yes, how many? _____

Was this a multiple birth? ❑yes ❑no If yes, how many? _____

Did this baby have breathing problems? ❑yes ❑no Was the cord around the neck? ❑yes ❑no

Did the baby cry quickly? ❑yes ❑no

Was the baby's color normal? ❑yes ❑no If no, was the baby blue or yellow? _____

If the baby was yellow (jaundiced), did he/she receive:

Oxygen? ❑yes ❑no If yes, how long? _____

Transfusions? ❑yes ❑no If yes, how many? _____

Phototherapy? ❑yes ❑no If yes, how many days? _____

Were there any other complications before you took the baby home? ❑yes ❑no

If yes, what? _____

Was the baby placed in an incubator or a special crib? ❑yes ❑no If yes, how long? _____

How long after the birth did you take the baby home? _____

EARLY HISTORY

General Information

Did the baby have any feeding problems? ❑yes ❑no If yes, please describe: _____

_____

Was the baby colicky? ❑yes ❑no If yes, how long? _____

Did the baby require formula changes? ❑yes ❑no If yes, please describe: _____

_____

Difficulty sucking as an infant? ❑yes ❑no Difficulty chewing? ❑yes ❑no

Drooling past 2.5 years? ❑yes ❑no

Was the baby normally active? ❑yes ❑no If no, please describe: _____

Was the baby limp? ❑yes ❑no Was the baby stiff? ❑yes ❑no

Did the baby show unusual trembling? ❑yes ❑no Did the baby fail to grow normally? ❑yes ❑no

Did the baby fail to gain weight normally? ❑yes ❑no

Was this baby different in any way from his/her brothers or sisters? ❑yes ❑no If yes, please describe:

_____

Motor Milestones

Age sat alone: _____ Age tied shoes: _____ Age walked alone: _____

Age fed self: _____ Age dressed self: _____ Age pedaled tricycle: _____

Age rode bicycle: _____ Age swam: _____

Language Milestones

Age spoke first words: _____ Age put 2-3 words together: _____

Age used good sentence structure: _____

Any speech problems? ❑yes ❑no If yes, describe: _____

_____

Toilet Training

Age trained for bladder: _____ Age trained for bowels: _____

Any bed wetting? ❑yes ❑no If yes, age started: _____ How often? _____

Age controlled: _____

Did child have urine accidents during the day? ❑yes ❑no Did child have soiling? ❑yes ❑no

MEDICAL HISTORY

Is your child up to date on all immunizations? ❑yes ❑no

If no, please specify:_____

Has your child had meningitis or encephalitis? ❑yes ❑no

If yes, at what age? _____

Has your child had any auto-immune disease or history of strep infection? ❑yes ❑no

If yes, at what age? _____

Has your child had a head injury? ❑yes ❑no If yes, was there a loss of consciousness? ❑yes ❑no

Multiple head injuries?_____

Did your child have any other significant injuries? ❑yes ❑no If yes, please specify: _____

_____

Has your child ever had a high or prolonged fever? ❑yes ❑no If yes, please specify: _____

_____

Did your child have frequent ear infections? ❑yes ❑no

Does your child have any visual defects? ❑yes ❑no Any hearing defects? ❑yes ❑no

Does your child have heart disease? ❑yes ❑no Does your child have asthma? ❑yes ❑no

Has your child had episodes of unconsciousness? ❑yes ❑no If yes, please explain: _____

_____

Has your child been hospitalized? ❑yes ❑no If yes, please specify: _____

_____

List any other uncommon childhood illnesses your child has had. _____

_____

Does your child frequently complain of any of the following?

Headache ❑yes ❑no Nausea ❑yes ❑no Dizziness ❑yes ❑no

Stomachaches ❑yes ❑no Chronic Constipation ❑yes ❑no Chronic Diarrhea ❑yes ❑no

Trouble with vision ❑yes ❑no Trouble with hearing ❑yes ❑no Weakness ❑yes ❑no

Describe any other frequent complaint(s): _____

_____

List any medications that your child has taken in the past for more than a month (include dosage given and reason it was taken): _____

_____

_____

List any medications your child is currently taking (including dosage and reason for taking it): _____

_____

_____

Complete the information for any of the following which you child has had:

Eye exam: Age _____ Results _____

Hearing exam: Age _____ Results _____

EEG: Age _____ Results _____

List any other special medical tests: _____

_____

Have you consulted any medical specialists about your child? ❑yes ❑no

If yes, who and why: _____

_____

_____

_____

BEHAVIORAL AND SOCIAL HISTORY

Who lives in the home? _____

_____

Are there significant marital/ adult conflicts? ❑yes ❑no

Are there significant conflicts between child and adults? ❑yes ❑no If yes, please describe: _____

_____

_____

Are there significant conflicts between the children? ❑yes ❑no If yes, please describe:

_____

_____

_____

Who disciplines and how? _____

_____

How does your child respond to discipline? _____

_____

Does your child have difficulty getting along with children his or her own age? ❑yes ❑no

If yes, please explain:_____

_____

Does your child have difficulty getting along with adults? ❑yes ❑no

If yes, please explain: _____

How does your child occupy him/herself? _____

_____

Check the following characteristics that describe your child:

❑Shy ❑Immature ❑Well-behaved ❑Stubborn ❑Impulsive

❑More active than other children ❑Clumsy using hands ❑Clumsy walking

Does your child currently or did your child ever have any of the following:

❑Temper tantrums ❑Poor handwriting ❑Sleep problems ❑Head banging

❑Nightmares ❑Toe walking ❑Blank spells ❑Thumb sucking ❑Falling spells

❑Tics or twitching

If so, describe: _____

_____

Did your child ever have difficulty staying with one activity for a reasonable length of time? ❑yes ❑no

Did your child ever eat paint, paper, etc.? ❑yes ❑no

Which hand does your child prefer? ❑right ❑left At what age was this preference established? _____

Does your child switch hands? ❑yes ❑no

Has your child had emotional, adjustment, or behavioral problems? ❑yes ❑no

If yes, please explain: _____

_____

Has your child received any psychological or psychiatric treatment? ❑yes ❑no

If yes, by whom? _____

When? _____ For what reason? _____

_____

Have you consulted with anyone about the current problem? ❑yes ❑no

If yes, with whom? _____

When? _____ Where? _____

SCHOOL HISTORY

Did your child attend a nursery school or a preschool program? ❑yes ❑no

Were there problems? ❑yes ❑no If yes, please describe: _____

_____

Check all problems your child's school has currently reported:

❑Behavior ❑Social adjustment ❑Attention span ❑Following directions

❑Completing assignments ❑Arithmetic ❑Reading ❑Spelling ❑Writing

Does your child like school? ❑yes ❑no

Is your child in a special education class? ❑yes ❑no If yes, what kind? _____

When was your child placed there? _____

Does your child receive any special services in school (resource room, tutorial, remedial reading, speech, etc.)? ❑yes ❑no If yes, please describe: _____

_____

For how long? _____

Have you gotten any help privately for your child? ❑yes ❑no If yes, please describe: _____

_____

FAMILY HISTORY

List children in order of birth

Family Member	Age	Education or Current Grade	Occupation	Health	School or Behavioral Problems
Parent (1)					
Parent (2)					

If anyone in your immediate family or other relative has any of the following, please indicate who:

Neurological disease _____

Seizures (epilepsy) _____

Hearing Problems _____

Visual Problems _____

Emotional Problems _____

Mental Retardation _____

Slowness in talking _____

Slowness in walking _____

Hyperactivity _____

Reading Problems _____

Learning Disabilities _____

Problems Similar to Your Child _____

Does any disease run in the family? ❑yes ❑no If so, describe _____

_____

_____

Additional Comments: