NORTHEAST REGIONAL EPILEPSY GROUP

The following questions are asked so that we can best understand your child. Please fill out this questionnaire before the child is evaluated. Please read the questions carefully and answer them as fully as possible. Use the back of the sheet if necessary.

Child's Information (Please print)

Name _____ Birth Date _____ Age _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work/Cell Phone _____

Email Address _____

Primary Doctor _____ Phone _____

Primary Neurologist: _____ Phone _____

School _____ Grade _____

Address _____

(if public, name of school district _____)

Person Completing this Form: _____

Relationship to Child: _____

Who referred you for this evaluation? _____

What are the primary reasons that caused you to seek help for this child?

1) _____

2) _____

3) _____

Family History

Child is living with:

☐ Both parents ☐ Mother ☐ Father

☐ Mother and Stepfather ☐ Father and Stepmother ☐ Legal Guardian

☐ Other (Please specify) _____

Is the child adopted? ☐ No ☐ Yes, child's age at adoption: _____

Status of parents' marriage:

☐ Married ☐ Separated ☐ Divorced

☐ Widowed ☐ Single

How long married? _____ How long Separated/divorced? _____ Child's age at divorce _____

	Mother or Step-mother	Father or Step-father
Name:		
Age:		
Race:		
Highest grade completed:		
Diploma/Degree:		
Occupation:		

Please describe any Medical and/or Neurological problems and treatment <u>received by the parents</u>:

_____ _____

_____ _____

Please describe any Psychological or Psychiatric problems for which treatment was <u>received by parents</u>:

_____ _____

_____ _____

Other Children (including step-siblings and half-siblings)

Name	Age	Gender	In home?	Learning, Developmental, Medical/Health problems

<u>Biological Extended Family</u>

Were any extended family members (maternal/paternal grandparents, uncles, aunts, cousins) diagnosed with **ADHD; Epilepsy, seizures or other neurological disorder; genetic disorders, alcoholism or substance abuse; psychological, psychiatric; learning problems Autism/Developmental Disorders**; ☐ No ☐ Yes, please list relationship to child, disorder, and any treatment received.

Maternal (mother's side)	Paternal (father's side)

Provide any other information about the child's extended family that might help us understand the child's needs (medical, developmental, behavioral, educational, emotional, or psychological).

_____

_____

Birth and Developmental History

Pregnancy

Was Child Full Term ☐ No; Preterm(length)_____ ☐ Yes; Postterm(length)_____

Any illnesses or medical complications while pregnant? ☐No ☐ Yes, please explain. ____

_____

_____

Medications taken by the mother **during** pregnancy? _____

_____

Substances used **during** pregnancy:

☐ Cigarettes How many? _____ per (☐ day ☐ week)

☐ Alcohol How many drinks? _____ per (☐ day ☐ week ☐ month)

☐ Drugs Please describe type(s) of drug, frequency of use, and at what month of pregnancy use was stopped (if applicable) _____

_____

Was the father taking any medications or drugs at time of **conception**? If so, what?

_____

Prior to the birth of this child, how many pregnancies and/or miscarriages has the mother had?

_____

Labor and Delivery

Was the birth of the child "normal" ☐ Yes ☐ No

Was the birth of the child by C-section ☐ Yes ☐ No

Did your child experience any pregnancy, birth, or neonatal complications: ☐ No ☐ Yes, please explain: _____

_____

Perinatal History

Child's Birth weight _____

APGAR 1-Minute _____ APGAR 5-Minutes _____

Did mother or baby stay in Special or Intensive Care: ☐ Yes ☐ No

Please describe any problems _____

_____

Infancy and Early Childhood

Has you child ever engaged in self-harm behaviors ☐ No ☐ Yes, please explain _____

_____

Please describe any behaviors that are particularly concerning to you or others.

_____

_____

Other problems or comments regarding infancy or early childhood development:

_____

_____

Please describe the child **as an infant** (temperament, sleeping, eating patterns, etc.)

_____

_____

Ages at Milestones

Gross Motor: crawled _____ walked alone _____ ran well _____

Fine Motor: fed self with spoon _____ scribbled _____ tied shoes _____

Language: used single words _____ Phrase Speech (2-4 words) _____

Early Sentences (4 or more words) _____

Toilet trained/day _____ Toilet trained/night _____

Rate of development overall: ☐ slow ☐ normal ☐ fast

Medical History

Has the child been taken to the emergency room with a serious emergency, had an illness or hospitalization, or had outpatient surgery since birth? ☐ No ☐ Yes. Please describe condition/injury, treatment, any surgery, when, how long, and where._____

_____

_____

Has the child ever been diagnosed with Epilepsy or a disorder of the central nervous system (stroke, traumatic brain injury, other)? ☐ No ☐ Yes, Child's age at time of Diagnosis _____

Explain _____

_____

_____

Has the child had a head injury: ☐ No ☐ Yes, Child's age: _____

Did he or she lose consciousness? ☐ No ☐ Yes, How long? _____

Was he or she comatose? ☐ No ☐ Yes, How long? _____

Has the child ever been diagnosed with a medical disorder? □ Yes □ No, if yes please explain

_____

_____

Has the child ever been diagnosed with a genetic disorder? ☐ No ☐ Yes, please explain

_____

_____

Has the child ever been diagnosed by a psychologist or physician as having an Autism Spectrum Disorder (Autism, Asperger disorder, Pervasive Developmental Disorder)? ☐ No ☐ Yes, when? _____

_____

Has the child ever been diagnosed by a psychologist or physician as having ADHD (Attention-Deficit/Hyperactivity Disorder)? ☐ No ☐ Yes, when? _____

_____

Has the child ever been diagnosed by a psychologist, physician or school district as having a learning disability (Reading, Written Language, Math)? ☐ No ☐ Yes, when? _____

_____

_____

Date of last hearing test _____ Were the results normal? ☐ Yes ☐ No, please explain. _____

Date of last vision test _____ Does the child wear ☐ Glasses? ☐ Contacts?

Why? _____

Please list **current** medications (with dosage and times) being taken by the child, including nonprescription medications.

1) _____
2) _____
3) _____
4) _____

Prescribing Physician(s) _____

Specialty _____

Please list **past** medications (with dosage and times) being taken by the child, including nonprescription medications.

1) _____
2) _____
3) _____
4) _____

Prescribing Physician(s) _____

Specialty _____

The child's current health is: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Behavioral and Mental Health History

Please list any unusual, traumatic, or possibly stressful events in the child's life that you think may have had an impact on his or her development and current functioning. Include incident, child's age at the time, and comments. _____

_____

_____

Has the child or family received any professional mental health treatment, such as individual or family counseling, group counseling, etc.? ☐ No ☐ Yes, please list any past and current treatments, including type of counseling, person counseled, name of counselor, and length of treatment _____

_____

Educational History

Did the child attend preschool or daycare? If so, list location, type of program, number of days per week, age when started, progress. _____

_____

Briefly describe the child's performance and any concerns in each grade:

Preschool _____

Kindergarten _____

1st grade _____

2nd grade _____

3rd grade _____

4th grade _____

5th grade _____

Middle School _____

High School _____

College _____

Has the child been placed in special education programs currently or in the past? ☐ No ☐ Yes, what grade was child first classified for special education _____

Classification _____

Services Received _____

_____

Has the child been placed in Gifted & Talented programs currently or in the past?

☐ No ☐ Yes; Type of Program _____

Child's Hobbies

1) _____

2) _____

3) _____

Special Skills, Talents or Interests

1) _____

2) _____

3) _____

Additional Information

Please attach results of any previous testing.

Please add any additional comments you think might be helpful.

_____

_____

_____

Signature: _____ _____

Individual completing form, relationship to child Date

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Neuropsychological testing of children

Typically involves a review of developmental, medical, and educational history, in addition to a thorough assessment of various cognitive abilities (e.g., attention, memory, language, visuospatial skills, and fine motor skills).

Don't forget to bring:

Medical records (including CT, MRI reports)

List of current medications

Previous neuropsychological, educational, Speech, OT, PT reports

School report cards

IEP paperwork (if applicable)

Any other historical information that could be of use

Reading glasses (if needed)

Try to make sure that your child has:

A good night's sleep

A good breakfast

And feel free to bring neat snacks for your child to eat or drink during the assessment. We will also break for lunch.

Testing can last from *3 to 5 hours*, so please plan your day accordingly. A full assessment may require a second appointment as determined by the neuropsychologist on the first day you are tested.

At least one parent/caregiver must be present at the office for the duration of the evaluation. Also, leave your cell phone number with the secretary if you go out for a few minutes (e.g. bathroom).

Please note that if you arrive 45 minutes later or more, your appointment will need to be rescheduled.
Lastly, note that each appointment time is tentative, and may be rescheduled or cancelled if authorization from medical insurance is not received in time before the day of the appointment.

A maximum of five hours have been reserved for you on this day for the evaluation. It is for this reason that we ask that if you are not able to keep this appointment that you call the number listed above at least 48 hours prior to avoid being charged.

Please also note that on the day of the evaluation, you will be responsible for any payment/copayment as applicable, which will be collected prior to testing. Payment can be made via cash, check, or credit card (Visa, Mastercard, or Discover). If your medical insurance does not cover the cost of the evaluation or does not cover the full cost of the evaluation, be aware that you will be responsible for payment of the evaluation in full (or remainder of the fee).

Once the evaluation is completed, a report will be ready in approximately three weeks after your last appointment. You will then be contacted by our office to make a feedback appointment to go over the results. You do not need to bring your child in for this appointment. It is necessary to review the findings with the neuropsychologist and not your referring physician because there are details regarding scores, performance and recommendations that only the neuropsychologist can explain fully. A copy of the report will be given to you and sent to your referring physician as soon as you speak with the neuropsychologist about your results.