Glassman Neuropsychology Associates LLC
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CHILD AND ADOLESCENT EVALUATION: PATIENT FORM

Sex: _____ Birthdate: _____ Provider:

Name: _____ Persons present for evaluation: _____ Form filled out by: _____

Evaluation date: _____ Referred by: _____

Briefly describe the events that led to this appointment

What concerns you most about your child?

What are your goals for the evaluation?

Have you seen other professionals about these problems? If yes, list these contacts and approximate dates of evaluation and treatment (include hospitalization dates).

Please list past and current medications and approximate doses and dates of treatment.

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Income level for MNB demographics

___$78,000+
___$44,000 - $78,000
___$22,000 - $44,000
___below $22,000

CHILD AND ADOLESCENT EVALUATION: PATIENT FORM

Patient: _____ Date: _____ Provider: _____

Developmental History

Pregnancy /neonatal/ infancy:

Were there complications with the pregnancy or your child's delivery (for instance, medications, prematurity, fetal distress, low Apgars, C-section)? Were there any medical problems in the first two years of life?

_____
_____
_____
_____
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_____
_____

Developmental milestones and concerns:

Did/does your child have problems with the following developmental milestones? Please note the dates you had concerns about the problem.

Feeding concerns? _____

Breast Feed? How long? _____

Physical growth problems? _____

Colic? _____

Sleep habits? _____

Sleep through the night? _____

Sleeping alone? _____

Age of walking? _____

Clumsiness? _____

Age of first words, first sentences? _____

Other language concerns? _____

Age of bowel training? Current Soiling? _____

Age of bladder training? Current wetting? _____

Hygiene concerns? _____

Problems separating from parents? _____

Past and current peer relations? _____

What do you see as your child's strengths and weaknesses?

_____
_____
_____
_____
_____
_____

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Patient: _____ Date: _____ Provider: _____

School History

What is your child's grade and school?

_____

What other schools has he/she attended?

_____
_____
_____
_____
_____

Has your child been in special education? Have there been learning problems? Give details of problems and supports.

_____
_____
_____
_____
_____
_____

Do you have concerns about the school program?

_____
_____
_____
_____
_____

Has there been psychological testing? When? Results? Bring to the evaluation if available.

_____
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_____

What is your child's attitude toward school?

_____
_____
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_____

What are your hopes for your child's educational attainment and vocational future?

_____
_____
_____
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_____

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Patient: _____ Date: _____ Provider: _____

Social History

List the names, ages, and occupations/grades of family members in the current household.

List immediate relatives (biological or related by marriage, parents or siblings) or other primary caretakers (sitters, day care) of the child outside the primary home. Has there been any significant history of problems with caretakers, such as abuse or neglect?

Are there any particular stresses or recent changes in the family such as job changes, financial problems, school changes, health problems, marriage or divorce, violence, or substance abuse?

Who is responsible for disciplining? What methods work or haven't worked? Do caregivers/parents agree on discipline? Is there allowance? Are there chores?

How well I does your child get along

with siblings? _____

with peers? _____

with parents? _____

by himself/herself? _____

What are family activities or mealtimes like? Does your child have other activities or hobbies? Favorite TV or movies?

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Patient: _____ Date: _____ Provider: _____

Medical History

Child's local physician _____

address _____

phone _____

date of last physical exam _____

Has your child seen a specialist, such as a neurologist, etc.? Please list names, approximate dates, and reasons for consultation.

_____
_____
_____
_____
_____

Allergies (environmental, food, and/or medication related)

_____
_____

Current medicines, or any medicine ever taken over 6 months duration (include over the counter or "natural" medicines).

_____
_____
_____
_____

Medical concerns (give details if applicable)

- ☐ Asthma or breathing problems
- ☐ Headaches
- ☐ Gastrointestinal concerns
- ☐ Head injury history
- ☐ Seizures
- ☐ Ear infections
- ☐ Frequent or recent strep infection
- ☐ Heart murmur or problems
- ☐ Hospitalizations or surgeries
- ☐ Hearing loss (testing done?)
- ☐ Vision problems
- ☐ Onset of puberty or menses
- ☐ Sexual activity
- ☐ Other medical concerns

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Family History

Please identify if there is a history of the following problems in the **child's genetic or natural family**, and indicate briefly the problem and relative (for example, seizures in a maternal aunt).

Alcohol or drug problems in family members

_____
_____
_____
_____
_____

Eating problems in family members

_____
_____
_____

ADHD or school behavior problems in family members

_____
_____
_____

Conduct problems or court involvement in family members

_____
_____
_____

Mental retardation, learning, disabilities, or other developmental problems

_____
_____
_____

Mood problems, including suicide, depression, or manic-depressive illness, treated or untreated in family members

_____
_____
_____

Anxiety and panic problems in family members

_____
_____
_____

Schizophrenia in family members _____

Neurologic problems such as seizures, or migraines

_____
_____
_____

Tics or Tourette disorder _____

Thyroid problems in family members _____

Genetic syndromes in family members _____

Cardiac or other medical problems in family members

_____
_____
_____

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PLEASE CIRCLE AND COMMENT AS APPROPRIATE:

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- ☐ careless / poor attention to details
- ☐ difficulty sustaining attention
- ☐ doesn't listen
- ☐ doesn't follow through with requests
- ☐ difficulty organizing
- ☐ avoids effortful tasks
- ☐ loses necessary things
- ☐ easily distracted
- ☐ forgetful in daily activities
- ☐ fidgets
- ☐ leaves seat
- ☐ runs about / subjectively restless
- ☐ difficulty playing quietly
- ☐ "On the go"/ "motor driven"
- ☐ excessive talk
- ☐ blurts out answers
- ☐ difficulty waiting turn
- ☐ interrupts/intrudes

Where are these problems present, in the home, in the school, or in other settings?
Comments:

_____
_____
_____
_____
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_____

- ☐ stealing in the home or out of home
- ☐ lying
- ☐ truancy/runaway
- ☐ violence in the family
- ☐ violence at school
- ☐ violence in the community
- ☐ fire setting or fireplay
- ☐ cruelty to animals
- ☐ legal involvement with juvenile services
- ☐ inappropriate sexual interests and behavior
- ☐ lack of conscience
- ☐ threats of violence
- ☐ exceptional negativity to rules

Comments:

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_____

- ☐ alcohol use
- ☐ marijuana use
- ☐ cigarette use
- ☐ other substance use

Comments:

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_____
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_____
_____

Patient: _____ Date: _____ Provider: _____

PLEASE CIRCLE AND COMMENT AS APPROPRIATE:

expresses depression or hopelessness or low self esteem

can be irritable or giddy or elated inappropriately

hypersexual or loss of other inhibitions

mood swings (circle period of change MINUTES, HOURS, DAYS, WEEKS, or MONTHS)

moods change without reason

lack of interest in friends or normal activities

poor sleep or excessive sleep

poor eating or excessive eating or concerns over weight changes or dieting

binging with or without purging (self induced vomiting)

suicidal talk or acts of self harm or mutilation

Comments:

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_____

school refusal or excessive absences

anxiety at bedtime or in the night / refusal to sleep alone

fears of harm to family members

complaints of physical symptoms such as headache or stomach ache

specific phobias (heights, spiders, etc.)

sudden feelings of panic

refusal to speak in public, or refusal to go out in public

history of trauma (abuse, accident, etc.)

nail biting, thumb sucking, teeth grinding, hair pulling, skin picking

excessive hand washing, or repetitive touching, or checking, or other "rituals"

overconcern regarding germs, illnesses, contamination by dirt, or other obsessive thoughts

overly perfectionistic

Comments:

_____
_____
_____
_____
_____

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Patient: _____ Date: _____ Provider: _____

PLEASE CIRCLE AND COMMENT AS APPROPRIATE:

tics or twitches of the mouth, eyes, facial muscles, or arms and legs

head banging or rocking

other repetitive behaviors causing self injury (biting, scratching, etc.)

other repetitive movements such as jumping or arm/hand flapping or spinning

lack of affection (doesn't seek out or provide comfort)

little need for reassurance in a strange situation, or little stranger anxiety

poor peer relations/ no real friends

problems understanding feelings of others during interactions

distress over changes in routine

unusual toy or play interests (collections, string, line up or take apart toys rather than play)

restricted conversational interests (dinosaurs or specific topics to the exclusion of other topics)

hoarding food or other objects

Comments:

_____
_____
_____
_____
_____
_____
_____
_____
_____

odd thinking or peculiar ideas

difficulty discerning what is real vs. normal fantasy play

paranoid thinking

hearing voices

seeing things not there

periods of odd sensations or loss of memory for a period of time

PLEASE ALSO COMMENT BELOW IF YOU HAVE OTHER CONCERNS NOT RAISED IN THE PREVIOUS SEVERAL PAGES

Comments:

_____
_____
_____
_____
_____
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_____

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