# Penfield Psychiatry • Finger Lakes Psychiatry

**PSYCHOLOGICAL/NEUROPSYCHOLOGICAL TESTING SERVICES**
**PEDIATRIC HISTORY QUESTIONNAIRE**

Patient's full Name: _____ Date: _____

Age: _____ Birth Date: _____ Sex: [ ] M [ ] F **[ ]** Other

Grade: _____ Ethnic/ Racial Background: _____

Primary Language: _____ Secondary Language: _____

Hand used for writing (check one): [ ] Right [ ] Left

Current problem areas/areas of concern: _____
_____
_____
_____

**II. EARLY HISTORY:**

Adopted: 1=yes 2=no
Duration of Pregnancy (please write in # of weeks): _____
Complications: ___excessive vomiting ___threatened miscarriage
___excessive staining/blood loss ___hospitalizations
___accidents or injuries ___toxemia
___illnesses (specify)_____

Smoking during pregnancy: No___ Yes___ Number of cigarettes per day:____
Alcohol use during pregnancy: No___ Yes___ Amount:_____/week
Medications/drugs during pregnancy: _____

**Type of Delivery --**
Vaginal ___ Cesarean ____ (state reason why):_____
Was labor spontaneous_____ or induced_____? Length of labor:_____
Complications:___ none ___ breech ___ forceps
___ Intraventricular Hemorrhage (IVH) ___ retinopathy
___ BPD/lungs ___ PDA/cardiac
___ cord around neck ___ other, please explain _____
Birthweight:___ lb ____ oz Apgar Scores (if known) _____ and _____

**Post-Delivery --**

Cyanosis (turned blue) Yes ___ No ___
Infection Yes ___ No___ (if yes, please specify)_____
Other illnesses or problems_____
How many days was your child in the hospital nursery before being discharged home?_____
Difficulty with feeding? Yes ___ No ___ (if yes, please explain)_____

**Developmental and Medical History --**

Age child crawled_____, sat _____, and walked _____
Did your child walk prior to 15 months? Yes____ No_____
Age child said first word _____, and talked in 2-3 word sentences _____
Did your child speak 1st words (mama, dada) prior to 12 months? Yes___ No____
Did your child speak in 2-3 word sentences prior to 2 years old? Yes____ No___
Does your child use gestures to help communicate his or her wants and needs? YES NO
Age child was toilet trained: _____ day _____ night.
Do accidents still occur during day? YES NO Do accidents still occur at night? YES NO

Did your child receive Early Intervention (EI) services prior to age 3? Yes____ No_____
Select which type of EI he/she received: speech____ occupational____ physical_____

Did your child receive interventions after age 3 through the school or privately? Yes_____ No_____
Select which type of intervention: speech_____ occupational_____ physical_____

Does your child show any of these conditions? (Check all that apply):

[ ] Attention Problems [ ] Head Injury
[ ] Muscle Tightness or Weakness [ ] Clumsiness
[ ] Hearing Problems [ ] Speech Problems
[ ] Frequent Ear Infections [ ] Learning Disability
[ ] Other Problems: _____ [ ] Behavior Issues

Has your child ever been tested for developmental disabilities (e.g., cerebral palsy, specific learning disabilities, autism, ADHD, etc.)? [ ] Yes [ ] No

**III. MEDICAL HISTORY: Please list past and current medical conditions.**

_____
_____
_____
_____
_____

Has your child ever been hospitalized? [ ] Yes [ ] No

If yes, describe: _____
_____

Has your child ever suffered a serious injury to their head? [ ] Yes [ ] No

If yes, describe: _____

**Medications:**

Please note all medications taken at present, their dosage, and frequency given.
Example: Depakote 100 mg. 2 tablets/ AM, 1.5 tablets/ afternoon, 4 tablets/ evening.

| **Name** | **Dosage/ Amount** | **Frequency Given** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**IV. FAMILY HISTORY:**

**Please check all that existed in close biological family members (parents, brothers, sisters, grandparents, aunts, uncles), note who it was, and describe the problem indicated:**

| Physical/Psychiatric Problems | Who | Describe |
|---|---|---|
| [ ] Neurological/Brain condition | _____ | _____ |
| [ ] Learning Disability | _____ | _____ |
| [ ] Mental Retardation | _____ | _____ |
| [ ] ADHD | _____ | _____ |
| [ ] Alcohol/Drug Dependency | _____ | _____ |
| [ ] Bipolar Disorder | _____ | _____ |
| [ ] Depression | _____ | _____ |
| [ ] Personality Disorder | _____ | _____ |
| [ ] Schizophrenia | _____ | _____ |
| [ ] Other Psychiatric Illness | _____ | _____ |
| [ ] Other Disease/ Disorder | _____ | _____ |

**V. PSYCHOSOCIAL HISTORY:**

People living in household with child:

| Name | Age | Relationship to child |
|---|---|---|
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |

Would you consider the current living situation/environment stressful? [ ] Yes [ ] No [ ] Maybe

What is your child's best attribute/characteristic (e.g. , friendly, hard worker)? _____

What is your child's worst attribute/characteristic (e.g. , stubborn, quick tempered)? _____

Describe any organizations, volunteering, hobbies, reading interests, or other leisure-time activities in which your child is *currently* engaged in:

_____
_____

**Psychological/ Psychiatric Symptoms and Services:**

Has your child ever been under the care of a psychiatrist, psychologist, or counselor?
[ ] Yes [ ] No

If Yes, what were they seen for? _____

Are they currently under the care of:
psychiatrist [ ] Yes [ ] No psychologist/counselor [ ] Yes [ ] No

**VII. EDUCATIONAL HISTORY:**

Name of School_____ County_____
Regular classroom placement_____ or Special Placement_____(explain)_____
Is your child being homeschooled? YES NO Since which grade? _____
Typical grades on report card _____
Has your child repeated any grades? Yes____ No____ If so, which grade(s)? _____
Has your child skipped any grades? Yes____ No____ If so, which grade(s)? _____
Easiest subjects_____
Difficult subjects_____
Has your child ever had an IEP? Yes __ No __ Section 504 plan? Yes __ No ___

Your child's IEP/504 is designated under which category at school?
Unknown ____ Autism ____ Other Health Impaired___ Specific Learning Disability (SLD) ____
Speech/ Language Impairment (SLI) ___Traumatic Brain Injury (TBI)__
Emotional Disturbance ____ Mental Retardation___ Orthopedic____
Deaf/Hearing/Visual/Deaf-Blindness_____ Multiple_____
During which grade was the IEP established? _____
Educational tutoring/Remedial activities (if any)_____

Describe any school problems: _____
_____
_____

**IX. SUBSTANCE USE HISTORY:**

Please check all the drugs your child/adolescent is using or have used in the past:

| | Presently Using the | Used in Past | Date |
|---|---|---|---|
| [ ] Alcohol | [ ] | [ ] | _____ |
| [ ] Tobacco | [ ] | [ ] | _____ |
| [ ] Caffeine | [ ] | [ ] | _____ |
| [ ] Amphetamines (including diet pills) | [ ] | [ ] | _____ |

| | | | |
|---|---|---|---|
| [ ] Barbiturates (downers) | [ ] | [ ] | _____ |
| [ ] Cocaine or crack | [ ] | [ ] | _____ |
| [ ] Hallucinogens/ LSD | [ ] | [ ] | _____ |
| [ ] Inhalants (glue, spray cans, etc.) | [ ] | [ ] | _____ |
| [ ] Marijuana | [ ] | [ ] | _____ |
| [ ] Opiate narcotics | [ ] | [ ] | _____ |
| [ ] PCP (angel dust) | [ ] | [ ] | _____ |
| [ ] Other drugs: _____ | [ ] | [ ] | _____ |