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Comprehensive Intake Questionnaire for Adolescent Evaluations

This questionnaire will help me best understand your child and his/her current difficulties. Read the questions carefully and answer them as fully as possible.

PLEASE NOTE:
-We recommend completing this questionnaire on a computer and not a mobile device.
-We recommend opening this questionnaire in Adobe Acrobat Reader, which can be downloaded here.
-Boxes outlined in red represent required items.
-You can save the information you enter in to this form and it is recommended that you periodically save the document as you complete it, so that you do not unintentionally lose your data. Once it is complete, follow the instructions given to you in email regarding how to upload your completed questionnaire.

Today's Date:

Name of person completing this form

Relationship to patient

PATIENT INFORMATION

Name of patient

Date of Birth

Age

Gender

Is your child right or left handed

Grade

Current School

School District

School Address

Home address

Length of time living in your current neighborhood

Parent 1 Name

Parent 1 Cell Phone

Parent 2 Name (if applicable)

Parent 2 Cell Phone (if applicable)

Preferred email

CURRENT REFERRAL

Who referred you to the Neuropsychology Center of St. Louis

Briefly state the main concern(s) for which you are presently seeking an evaluation for your child:

When were these concerns first noticed?

What interventions or treatments have been implemented to address your concerns?

What was the outcome of these attempts? What seems to help/make it worse?

Does this referral have, or have the potential for, legal involvement? *If there is a potential for legal involvement, please note the information related to Legal Cases in the Informed Consent form.*

◯ Yes ◯ Maybe ◯ No

CURRENT FUNCTIONING

List all conditions/illnesses for which your child is being treated:

Current learning and/or psychiatric diagnoses (when listing diagnoses, please indicate who diagnosed each condition):

List any known genetic disorders or medical diagnoses:

Name of child's Pediatrician:

Office Phone Number of Pediatrician:

Name of any Specialty Physician currently involved in your child's care:

Office Phone Number of Specialty Physician:

Name of Psychiatrist:

Office Phone Number of Psychiatrist:

(No information will be released or obtained without your written permission)

Has your child ever had a psychiatric or neurological examination? If Yes, please provide additional details below.

Does your child wear a hearing aid?

◯ Yes ◯ No

Does your child wear glasses/contact lenses?

◯ Yes ◯ No

Use the following fields to list all current medications, current dosages and length of time your child has been on each medication. Please include both prescription and over-the-counter medications.

Name of medication(s)	Dose	Length of use (dates)	Prescribing physician

If additional space is needed, use the following space:

Are there any changes in this child's behavior (increased or decreased energy, attention, etc.) when he/she is on medications? If so, please describe below.

Does your son/daughter currently have a job?

◯ Yes ◯ No

Has your son/daughter ever had a job?

◯ Yes ◯ No

MEDICAL HISTORY

Please list, chronologically, any illnesses diagnosed and their treatments for this child from infancy to the present. Include any problem that required medical attention above and beyond normal childhood problems (i.e. flus, colds, strep throat).

Age	Diagnosis	Treatment/Outcome

If additional space is needed, use the following space:

Has this child ever experienced a head injury?

- ◯ Yes (continue to answer the following questions specific to head injuries)
- ◯ No (skip to next question regarding seizures after the horizontal line)

If Yes, complete the following:

Date of head injury

Cause of injury:

Length of time unconscious (if applicable)

Effect of injury on functioning:

List any treatments given:

Did your child engage in inpatient rehabilitation?

- ◯ Yes (see question to the right)
- ◯ No

If Yes, where did this occur and for how long?

Did your child engage in outpatient rehabilitation?

- ◯ Yes (see question to the right)
- ◯ No

If Yes, where did this occur and for how long?

Did you notice any changes in your child's behavior, thinking, memory, or personality following this injury? If yes, please describe:

Has your child ever had seizures?

- ◯ Yes (continue to answer the following questions specific to seizures)
- ◯ No (skip to the question about sleep after the next horizontal line)

Age of onset of seizures

Frequency

Specific diagnosis:

Treatments given:

Have you ever had concerned that your child does not get enough sleep and/or has poor sleep quality?

- ◯ Yes (check off the kinds of concerns you had/have regarding sleep below)
- ◯ No (skip to the two questions after the next horizontal line)

Sleep concerns:

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Restlessness
- ☐ Nightmares
- ☐ Night terrors
- ☐ Snoring
- ☐ Sleep walking
- ☐ Talking in sleep
- ☐ Other

What time does your child go to bed?

What time does your child get up?

Continue to the next page

Please indicate whether your child has had any of the following:

	Yes	No
Migraines/headaches	○	○
Meningitis	○	○
Encephalitis	○	○
Coma or loss of consciousness	○	○
Anemia	○	○
Broken bones	○	○
Asthma	○	○
Sinus condition	○	○
Allergies to food	○	○
Allergies to medicine(s)	○	○
Environmental allergies	○	○
Frequent colds	○	○
Shortness of breath with exertion	○	○
Dizziness with exertion	○	○
Heart condition	○	○
Excessive vomiting	○	○
Frequent diarrhea	○	○
Constipation	○	○
Stomach pain	○	○

(Continued from previous page)
Please indicate whether your child has had any of the following:

	Yes	No
Genitourinary Concerns	◯	◯
Urination in pants/ bed	◯	◯
Pain with urination	◯	◯
Strong urine odor	◯	◯
Musculoskeletal Concerns	◯	◯
Muscle pain	◯	◯
Clumsy walk	◯	◯
Poor posture	◯	◯
Other muscle problems	◯	◯
Skin Concerns	◯	◯
Frequent rashes	◯	◯
Bruises easily	◯	◯
Sores	◯	◯
Eczema	◯	◯
Speech Concerns	◯	◯
Stuttering	◯	◯
Unclear speech	◯	◯
Other speech problems	◯	◯
Accident prone	◯	◯
Sucks thumb	◯	◯
Grinds teeth	◯	◯

(Continued from previous page)
Please indicate whether your child has had any of the following:

	Yes	No
Bites nails	◯	◯
Picks skin	◯	◯
Tics/Twitches	◯	◯
Bangs head	◯	◯
Rocks back and forth	◯	◯
Unusual body movements	◯	◯

Has your child ever had brain imaging (CT scan, MRI, etc.)? If Yes, please provide details below. If no, type "No".

Please list any surgeries your child has had including the type of surgery and date of surgery.

Please list any medication(s) taken by your child in the past for longer than 3 months duration. Be sure to include 1) Name of Previous Medication(s), 2) Dosage and 3) Dates child took the medication.

Name of medication(s)	**Dosage (if known)**	**Length of use (dates)**

Use the area below if additional space is needed:

PSYCHIATRIC HISTORY

Please describe any psychiatric or psychological evaluations or treatments your child has received. Indicate the child's age, the circumstances that required the evaluation/treatment, the treatment given and the outcome (i.e., did the treatment help?). If none, type "None"

Does your child have any history of drug or alcohol abuse? If yes, please describe. If no, type "No".

Has your child ever attempted suicide? If yes, please indicate when and describe circumstances. If no, type "No".

Has your child ever had difficulty or contact with police or juvenile authorities? If yes, please describe circumstances and provide dates. If no, type "No".

Has the Division of Family Services had any involvement with this child or other family member?
If yes, please explain and provide dates. If no, type "No"

FAMILY HISTORY

Who lives in the home with the child?

Status of parents' marriage:

☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed

☐ Other

If married, how many years:

If separated or divorced, child's age at separation/divorce:

Please indicate if the following are present in the child's life:

☐ Step-mother

☐ Step-father

Who is/are the legal guardian(s) of the child?

Is your child adopted?

◯ Yes (see question to the right)

◯ No

Child's age at adoption:

Please complete the following information regarding biological or adoptive parents in the appropriate column:

	Parent 1	**Parent 2**
Age		
Highest level of education completed		
Degrees/Diplomas		
Current occupation		
Describe any special education or tutoring received		
Describe grades repeated or subject areas that were difficult		

Any diagnosed learning difficulties?

If so, in what area(s)?

Any psychological or psychiatric problem for which treatment was received?

Any Attention Deficit Disorder (with or without Hyperactivity?)

In the section below, please list any other children in the family (including step-siblings and half-siblings)

Name	**Gender**	**Age**	**Lives in home?**	**Social/Behavioral/ Health problems**
			◯ Yes ◯ No	
			◯ Yes ◯ No	
			◯ Yes ◯ No	
			◯ Yes ◯ No	
			◯ Yes ◯ No	

Please list any non-residential adults involved with this child on a regular basis:

Have you or any of your relatives experienced difficulties similar to those your child is experiencing? If yes, please describe, if not, type "No"

Biological Family

Have there ever been any suicide attempts or completions by parents, siblings, relatives, or close relatives or close friends of this child?

◯ Yes ◯ No

If yes, please describe:

Have any family members (immediate, maternal/paternal grandparents, uncles, aunts, cousins) experienced difficulties from any of the following: inattentiveness or hyperactivity; behavior problems; learning difficulties; etc.

◯ Yes ◯ No

If yes, please describe:

Relationship to Child	**Type of Difficulty**	**Dates and Type of Treatment**

Is there any history of alcohol or drug abuse by parents, siblings, or other family members?

◯ Yes ◯ No

If yes, please describe:

Relationship to Child	**Dates and Type of Treatment**

Have any family members (immediate, maternal/paternal grandparents, uncles, aunts, cousins) been diagnosed with any of the following medical problems: seizures; migraines; genetic conditions, other neurological conditions etc.

◯ Yes ◯ No

If yes, please describe:

Relationship to Child	Diagnosis	Dates and Type of Treatment

Have any family members (immediate, maternal/paternal grandparents, uncles, aunts, cousins) been diagnosed with any of the following psychiatric/psychological problems: psychological, emotional or personality difficulties; depression or bipolar disorder; schizophrenia; developmental disabilities; Autism or Asperger's disorder; Anxiety or "nervousness" etc.

◯ Yes ◯ No

If yes, please describe:

Relationship to Child	Diagnosis	Dates and Type of Treatment

Please provide any additional information about your child's family/extended family that might help me understand your child's needs (medical, behavioral, psychological, educational, and emotional):

DEVELOPMENTAL HISTORY

Pregnancy/Birth History

Length of pregnancy in weeks

Did you experience any of the following complications during pregnancy with this child?

- ☐ Hospitalization during pregnancy
- ☐ X-rays during pregnancy
- ☐ Medication during pregnancy
- ☐ Alcohol during pregnancy
- ☐ Cigarettes during pregnancy
- ☐ Other drugs during pregnancy
- ☐ Drugs while trying to conceive (mother)
- ☐ Drugs while trying to conceive (father)
- ☐ None of the above
- ☐ Other

If you marked any complications above, please describe below including (if applicable) what month of pregnancy the complication occurred, what medication(s) was/were taken, the frequency of any tobacco or alcohol use, and the type and frequency of any drugs used during pregnancy.

Mother's age at birth of child Father's age at birth of child

Was the child born in a hospital? ◯ Yes ◯ No

Length of labor (in hours)

Birth weight: lbs. oz.

Apgar scores (if known)

Child's condition at birth

Number of days in the hospital

Check any of the following that applied to the child's delivery:

- [ ] Vaginal delivery
- [ ] Caesarean section (C-section)
- [ ] Forceps used
- [ ] Breech birth
- [ ] Induced labor
- [ ] Delivery complications
- [ ] Incubator needed
- [ ] Jaundiced
- [ ] Bilirubin lights
- [ ] Breathing problems right after birth
- [ ] Supplemental oxygen given
- [ ] NICU stay
- [ ] Other

If you marked any complications above, please provide any additional relevant details below.

Do you think this child's current difficulties might be related to pregnancy, labor or delivery?

- ◯ Yes
- ◯ No

If Yes, provide an explanation here:

Did this child have frequent ear infections as an infant?

◯ Yes ◯ No

Did this child have ear tubes inserted surgically?

◯ Yes ◯ No

Infancy/Childhood

Milestones
Gross Motor, fine motor, and Language milestones:
At what age did this child first do the following (in months)?

Turned over		Fed self with spoon		Crawled	
Sat alone		Scribbled		Stood alone	
Understood first words		Spoke first words		Spoke in sentences	

Did your child have difficulty learning how to do any of the following (check all that apply):

- ☐ Ride a bike
- ☐ Throw and/or catch a ball
- ☐ Skip, hop jump
- ☐ My child did not have any difficulty with any of the above activities

At what age did this child master the following? (report as months)

Daytime bladder control

Nighttime bladder control

Daytime bowel control

Nighttime bowel control

Did bed-wetting and/or bed soiling occur after training?

- ◯ Yes (answer question to the right)
- ◯ No

If Yes, until what age?

Has this child ever received Occupational Therapy?

- ◯ Yes (answer question to the right)
- ◯ No

If Yes, provide details:

Has this child ever received Physical Therapy?

- ◯ Yes (answer question to the right)
- ◯ No

If Yes, provide details:

Has this child ever received speech and/or language therapy?

- ◯ Yes (answer question to the right)
- ◯ No

If Yes, provide details:

<u>Infancy and Early Childhood</u>

Please rate this child on the following behaviors. Check 1 if the behavior on the left was present the majority of the time and check 5 if the behavior on the right was present the majority on the time. Stages in between are represented by 2, 3, and 4.

Quiet and content.....Colicky and Irritable

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Very easy to feed.....Daily feeding problems

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Slept well.....Daily/frequent sleeping problems

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Usually relaxed.....Often restless

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Underactive.....Overactive

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Cuddly, easy to hold.....Did not enjoy cuddling

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Easily calmed down.....Tantrums and/or head banging

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Cautious and careful.....Accident prone and/or daredevil

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Coordinated.....Uncoordinated

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Enjoyed eye contact.....Avoided eye contact

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Liked people.....Disliked contact with people

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Use the space below to provide any other comments/problems regarding infancy or early childhood development:

Did any event, health condition, separation etc. disturb infant/parent bonding or the developing toddler/parent relationship?

◯ Yes ◯ No

If Yes please describe:

EDUCATIONAL HISTORY

Please identify all preschools/daycares and schools your child has attended giving dates of attendance in sequential order.

Name of Preschool/Daycare/School	From (date) To (date)	# Days/week # Hours/day

Briefly describe any problems occurring during your child's attendance at these previous schools:

Has your child ever been retained a grade in school?

◯ Yes ◯ No

Has your child ever skipped a grade in school?

◯ Yes ◯ No

Has your child had difficulty with reading?

◯ Yes ◯ No

If Yes, please describe:

Has your child had difficulty with math?

◯ Yes ◯ No

If Yes, please describe:

Has your child had difficulty with writing/ spelling?

◯ Yes ◯ No

If Yes, please describe:

Does your child like going to school?

◯ Yes ◯ No

Do you have concerns about the quality of your child's school and/or teachers?

◯ Yes ◯ No

Has your child ever had psycho-educational testing either by your school district, special school district or by a private practitioner? *If Yes, please forward copies of report(s) for review.*

◯ Yes ◯ No

Has your child been identified as exceptional, or gifted? *If Yes, please forward copies of report(s) for review.*

◯ Yes ◯ No

Is your child currently receiving any special education services? *If yes, please forward copies of IEP or 504 plan for review.*

◯ Yes ◯ No

Does your child receive any private tutoring outside of his/her regular school schedule?

◯ Yes ◯ No

If Yes, please provide details:

SOCIAL/EMOTIONAL FUNCTIONING

The following questions are designed to assess your child's ability to relate to other children.
Please check each of the following that are TRUE for your child

- ☐ My child has difficulty relating to other children.
- ☐ My child physically fights a lot with other children.
- ☐ My child verbally argues a lot with other children.
- ☐ My child prefers playing with younger children
- ☐ My child has difficulty making friends.
- ☐ My child has difficulty maintaining friendships
- ☐ My child has at least one good friend.
- ☐ My child is invited to other friends' houses.
- ☐ My child likes to host others at our house.
- ☐ My child has a small group of good friends.
- ☐ My child prefers to be alone.
- ☐ My child has difficulty with non-verbal rules of social interaction (e.g., turn taking, how close to stand to others, etc.)
- ☐ I mostly like my child's choice of friends.

Describe the role your child takes with peer interactions:

Please describe the way your child is related to by peers?

Use the following space to provide any additional comments about your child's interactions with others.

Please describe any major family or parental stressors that may have impacted your child in the past or that may impact him or her now:

Is your child enrolled in any extracurricular activities or hobbies (e.g. team or individual sports, music lessons, karate, boy/girl scouts, etc.). If so, please list:

Please place a check in the box next to the traits/characteristics below which apply to your child NOW:

- ☐ Happy
- ☐ Friendly
- ☐ Independent
- ☐ Affectionate
- ☐ Tantrums
- ☐ Too responsible
- ☐ Impulsive
- ☐ Explosive
- ☐ Thoughtful
- ☐ Cooperative
- ☐ Sad
- ☐ Quiet
- ☐ Dependent
- ☐ Fearful
- ☐ Lethargic
- ☐ Even tempered
- ☐ Angry
- ☐ Volatile
- ☐ Dreamer
- ☐ Withdrawn
- ☐ Moody
- ☐ Overactive
- ☐ Sensitive
- ☐ Requires a lot of parental attention
- ☐ Short attention span
- ☐ Lacking in self control
- ☐ Withholding of affection
- ☐ Difficulty calming down
- ☐ Easily over-stimulated
- ☐ Overreacts when faced with a problem

Other words you would use to describe your child:

List any changes which have occurred for your child or the family over the last several years (i.e., relocations, deaths, separations, divorce, remarriage, parental job change, someone significant moving out of this area, experience of a traumatic event or witness of a traumatic event, etc.) Please indicate the date and type of event.

Are there any other particularly traumatic or troubling events which have happened in this child's life that I should know about in order to understand him/her better? (please give details, include incidents you feel were traumatic for this particular child, though they might not have been for another child)

Has your child ever witnessed violence inside or outside of the home?

◯ Yes ◯ No

Give a brief description of this child's relationship with:

Mother/Parent 1:

Father/Parent 2:

Step-parent (specify):

Grandparent (specify):

Brother(s) (if applicable):

Sister(s) (if applicable):

What are your child's areas of greatest accomplishment?

What does your child *enjoy* doing the most?

What does your child *dislike* doing the most?

Describe some of your child's positive attributes:

Is there any additional information or anything that you feel is pertinent to know regarding your child that has not been covered in this questionnaire?

What do you hope will result from seeking comprehensive neuropsychological assessment services?

You have reached the end of the questionnaire. Please save your work by selecting File-->Save or by clicking the save button in the tool bar: