



NeuroDevelopment, LLC
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Today's Date _____ Referred By: _____

Child's Name _____ Child's Birthday _____ Age _____

Home Address _____ Home Phone () _____

City _____ State _____ Zip Code _____

Father's Name _____ Birthdate/Yr _____

Father's Employer _____ Work Phone _____

Mother's Name _____ Birthdate/Yr _____

Mother's Employer _____ Work Phone _____

Brothers – Sisters (Names and Ages) _____

Is Child Adopted? _____ At What Age? _____

Others Living at Home _____

Child Living With: Both Parents Father Mother Stepfather Stepmother Foster Parents Others

Child is in Grade _____ Child's School _____

DEVELOPMENTAL HISTORY

Age held head up: _____
 Age crawled: _____ Age walked: _____
 Speech problems noted at what age: _____
 Shy or timid baby? _____
 Friendly baby? _____
 Fussy (colicky)? _____
 Eating habits as a baby? _____
 Temper tantrums as a baby? _____
 Too active as a baby? _____
 Toilet trained when? _____
 Difficulties toilet training? _____
 Right or left handed? _____
 Others in family who are right handed _____

 Others in family who are left handed _____

 Sleeping habits during early childhood: _____

 Difficult as a baby? How? _____

CURRENT DESCRIPTION

Current speech problems? _____
 Shy or timid now? _____
 Friendly now? _____ A loner now? _____
 Fussy or picky now? _____
 Concerns with present eating habits? _____

 Temper tantrums continued until: _____
 Too active now? _____
 Any problems with wetting or soiling now? _____

 When did child begin to favor preferred hand?

 Coordination now: Good O.K. Poor
 Good with hands? _____ Clumsy? _____
 Accident prone? _____
 Sleeping habits now: _____
 Bedtime is when? _____ Cooperative? _____
 Blank spells, fainting? _____

MEDICAL HISTORY

Has Your Child Had:

	YES	NO	AGE	DESCRIBE
Epilepsy/Seizures				
Speech/Language Problems				
High Fever (Over 103°)				
Abscessed Ears				
Allergies				

	YES	NO	AGE	DESCRIBE
Asthma				
Head Injury				
Hospitalization/Surgery				
Genetic Testing				
Extended Illness				

Any medical problems now? _____

Is your child taking any medications now? _____

Does child wear glasses or contacts? _____ Child's eye doctor is: _____

Has child had a recent hearing evaluation? _____ When? _____

Child's ear doctor: _____

SCHOOL HISTORY

According to school personnel (teachers, principals, counselors, etc.) child has had problems with:

behavior speech mathematics reading listening writing spelling attention motivation

Other concerns: _____

Child has been given individual intelligence or achievement tests: yes no

Reports have been given to me about the results: yes no

Name of psychologist/evaluator: _____

Child has received:

special education remedial education individual tutoring resource room services

Special help has been received in what subjects? _____

When? _____

Child's overall adjustment to school (circle a number) Poor _____ Excellent
1 2 3 4 5 6 7 8 9 10

Comment: _____

Child's attitude towards school: likes indifferent hates

Comment: _____

Has child repeated a grade? yes no Which one? _____