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Child History

The following questions are asked so that we can best understand your child. Please fill out this questionnaire, print it, and bring this form with you to your first appointment. Please read the questions carefully and answer them as fully as possible. Use the back of the sheet if necessary. If there are any questions you don't understand, they can be filled out with the provider's help when he or she reviews the history with you. Please star (*) such questions.

CHILD'S INFORMATION

Legal Name _____ Date of birth _____ Age _____

Mother's name _____

Home Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Father's name _____ Home Phone _____

Home Address (if different from previous address) _____

City _____ State _____ Zip Code _____

Please list your concerns and reasons for seeking services for this child:

FAMILY HISTORY

Child is living with: Both Parents Mother Father Mother and Stepfather

Father and Stepmother Legal Guardian Other (please specify) _____

If adopted, what was the child's age at adoption _____

Current status of child's parents' marriage: Married Separated Widowed Single Divorced

Length of current marriage: _____

If divorced, how long have you been divorced? _____ Child's age at the time of divorce: _____

Who has legal custody of child? Both parents Mother Father Other

PARENTS HISTORY

Complete those that apply

	Birth Mother	Birth Father
Age		
Highest grade completed		
Diploma/Degree		
Occupation		
Special Education		
Repeated a grade		
Learning Disability		
Attention-Deficit/Hyperactivity Disorder		
Speech/Language difficulty		
Emotional/Behavior problems		

Adoptive Mother

Stepmother

Other _____ (check one)

Highest grade completed _____

Occupation: _____

Adoptive Father

Stepfather

Other _____ (check one)

Highest grade completed _____

Occupation: _____

Other Children

(including step-siblings and half-siblings)

Name	Age	M/F	Living at home?	School/behavioral/health problems?

Biological Extended Family

Do any extended family members (maternal/paternal grandparents, uncle, aunts, cousins) suffer from any of the following problems:

- Inattentiveness Hyperactivity Epilepsy Seizures Migraines
- Alcoholism Drug abuse Arrests Incarceration Learning problems
- Developmental Disabilities Seizure Disorder Depression Anxiety Personality issues
- Schizophrenia Bipolar Disorder Attention-Deficit/Hyperactivity Disorder
- Other emotional or psychological difficulties, describe: _____

Please 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.) _____

Please provide any information about your family's religion or culture that you feel is important for us to understand: _____

Birth and Developmental History

Pregnancy

Length in months _____ Any maternal illnesses or complications while pregnant? Yes No

If yes, please explain _____

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

Substances **used during** pregnancy:

Cigarettes: How many? _____ per day Alcohol: How many drinks? _____ per day _____ per week

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?

How many pregnancies and/or miscarriages had the mother had before this child? _____

Labor and Delivery

Were there any problems during pregnancy, labor, or delivery? Yes No If yes, please explain.

Was your child born via: vaginal delivery cesarean section

Was the birth planned emergency in hospital home other _____

Perinatal History

Birth weight _____ Length _____ APGAR scores (if known) _____

Did the mother or baby stay in Special or Intensive Care? No Yes, how long? _____

Please describe any complications. _____

Infancy and Early Childhood

Please describe you child's temperament:

Quiet and content	1	2	3	4	5	Colicky and irritable
Very easy to feed	1	2	3	4	5	Daily feeding problems
Slept well	1	2	3	4	5	Frequent sleeping problems
Usually relaxed	1	2	3	4	5	Often restless
Underactive	1	2	3	4	5	Overactive
Cuddly, easy to hold	1	2	3	4	5	Did not enjoy cuddling
Easily calmed down	1	2	3	4	5	Hard to calm down
Cautious and careful	1	2	3	4	5	Adventurous and impulsive
Coordinated	1	2	3	4	5	Uncoordinated/clumsy
Enjoyed eye contact	1	2	3	4	5	Avoided eye contact
Liked people	1	2	3	4	5	Disliked contact with people

Other problems or comments regarding infancy or early childhood development.

Did any event, health condition, separation, etc., disturb early infant/parent bonding or the developing toddler/mother relationship? Yes No If yes, please explain. _____

List Ages at Milestones

Gross Motor	Crawl	Walk	Well-coordinated
Fine Motor	Fed Self	Scribbled	Tied Shoes
Language	Single Words	Sentences	Good Command of Language
Social/Adaptive	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, been hospitalized, or had outpatient surgery since birth? Yes No If yes, please describe condition/injury, treatment, any surgery, when, how long, and where. _____

If the child had a head injury: Did he or she lose consciousness? Yes No For how long? _____

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? _____

Does the child have any chronic illnesses or disabilities? If yes, please describe, along with any adaptive equipment or devices used on a regular basis: _____

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

The child's current health is: poor fair good excellent

How well does your child sleep? poor fair good excellent

Describe any nighttime issues: _____

BEHAVIORAL AND MENTAL HEALTH HISTORY

Please describe 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 prior professional mental health treatment, such as individual, family counseling or group counseling, etc? Yes No

Please list any past and current treatments, including type of counseling, person counseled, and length of treatment:

Has the child ever been diagnosed by a psychologist, physician, or other professional? Yes No

If yes, when and what was the diagnosis? _____

What treatment (**not medication**) has the child had? _____

Present Personality and Behavior

Please check all traits that apply to the child **now**:

Sad	Happy	Leader	Follower	Moody
Friendly	Quiet	Overactive	Independent	Dependent
Sensitive	Affectionate	Fearful	Cooperative	Tantrums
Lethargic	Too responsible	Trouble sleeping	Hard to discipline	Aggressive
Even-tempered	Prefers to be alone	Anxious	Shy	Unusual

Has your child ever been bullied or abused (physically, emotionally, or sexually)? Yes No

Does your child have any suicidal or aggressive intentions? Yes No

Has your child ever been arrested or involved in any criminal activity? Yes No

Is your child involved in any alcohol or recreational drug use? Yes No

Are there any concerns regarding sexual behavior? Yes No

Please review the following list of characteristics, and check all that apply:

Not at all	Somewhat	A Lot	Does your child have any of the following troubles?
			Fidgets
			Difficulty remaining seated
			Difficulty playing quietly
			Often talks excessively
			Runs about or climbs excessively
			On the go or acts as if driven by a motor
			Difficulty awaiting turn
			Often blurts out answers to questions before completed
			Often interrupts or intrudes on others
			Often engages in physically dangerous activities
			Difficulty following instructions
			Difficulty sustaining attention
			Shifts from one activity to another
			Often does not listen
			Often loses things
			Easily distracted
			Gives up easily
			Inconsistent performance

Not at all Somewhat A lot

Poor motivation
 Disorganized
 Doesn't finish tasks
 Low frustration tolerance
 Poor handwriting
 Mood swings

Often loses temper
 Often argues with adults
 Often actively defies or refuses adult requests or rules
 Often deliberately does things that annoy other people
 Often blames others for own mistakes
 Is often touchy or easily annoyed by others
 Is often angry or resentful
 Is often spiteful or vindictive
 Often swears or uses obscene language

Depressed or irritable mood most of day, nearly every day
 Diminished pleasure in activities
 Agitation or sluggishness
 Feelings of worthlessness or excessive inappropriate guilt
 Poor appetite or overeating
 Trouble sleeping or sleeps too much
 Low self-esteem
 Poor concentration or difficulty making decisions
 Feelings of hopelessness

Repeated unusual movements
 Odd postures
 Excessive reaction to noise or fails to react to loud noises
 Overreacts to touch
 Compulsive rituals
 Motor tics
 Vocal tics

Can't get to the point, loses train of thought
 Bizarre ideas (e.g., odd fascinations, strange ideas, hallucinations)
 Disoriented, confused, staring, or "spacey"
 Incoherent speech (mumbles, uses words only child understands)
 Excessive mood swings
 Explosive temper with minimal provocation
 Excessive clinging, attachment, or dependence on adults
 Unusual fears, repetitive worries
 Panic attacks
 Excessively monotonous or bland affect
 Situationally inappropriate emotions
 Little or no interest in peers or friends
 Significant indiscreet remarks
 Initiates or terminates interactions inappropriately
 Abnormal social behavior
 Excessive reaction to changes in routine

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. _____

Current grade and school _____

List previous schools and grades attended at each _____

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

Kindergarten _____

1st grade _____

2nd grade _____

3rd grade _____

4th grade _____

5th grade _____

Middle School _____

High School _____

Has the child received special education programs currently or in the past? Yes No

Category _____

Learning Disability (LD): Subjects _____

Language Disorder: Type _____

Speech/Language/Occupational Therapy: _____

Other: _____

Tutoring: Subjects _____

ADDITIONAL INFORMATION

What do you see as the child's greatest area of strength? _____

Please add any additional concerns or comments: _____