Neuropsychology and Educational Clinic
for Children and Adolescents
Karen P. Kelly, Ph.D.

IDENTIFYING INFORMATION OF CHILD

Child's Name: ____

Last First Middle Nickname

Birth date: _________________

Age_____

Grade _____

School ____

Sex: Male Female

Name of person completing form: ________________________

Relationship to child: _________________________

Date Completed: ___________________________

____

Street Address

____

City State Zip County

Home Phone: _____________

Second Phone: ____________

Parent’s Email: ___________________

Current physician:____

Address of Physician:____

Phone of Physician:____

Referred to Dr. Kelly by: _________________________________

FAMILY INFORMATION

Mother's Name: ___________________________________

Age: __________________

Education (highest grade): _________________________

Place of Employment: ____

Occupation: ____

Telephone: ____

Email:____

Father's Name: ____

Age: _________________

Education (highest grade): _____________________________

Place of Employment: ____

Occupation: ____

Telephone:____

Child's Legal Guardian (if any):____

Marital Status of Biological Parents: ____

Brothers and Sisters: (Please include and indicate half-brothers/sisters)

Name _______________________________________
Age ____________________________________
Learning & Medical Problems _________________________

Name _______________________________________
Age ____________________________________
Learning & Medical Problems _________________________

Name _______________________________________
Age ____________________________________
Learning & Medical Problems _________________________

Reason for requesting evaluation (developmental or behavioral concerns/academic progress)?

____

____

____

Has your child ever been given a medical, developmental, psychological, language, motor, or other diagnosis? If so, what was the diagnosis and who made the diagnosis?

____

MOTHER'S PREGNANCY HISTORY

Were there any problems experienced during pregnancy with this child? Yes _____No_____

If Yes, please explain: ____

____

Were any substances used during pregnancy? (e.g., alcohol, tobacco, drugs). Yes ____ No_____

If so, please specify.____

Was baby delivered early, on time, or late? _____________________________

Weeks gestation (if known) ______________________________

Labor and Delivery

Labor: Normal _________________________________

Delivery Normal ________________________________

Forceps used? ______________________________________

C-section? _____________ Reason _____________________

BIRTH HISTORY

Hospital child was born in: __________________________________

Birth weight: Pounds_____ Ounces____Length_____________

Apgar Scores (if known) _______ _______

If your child experienced difficulties during labor or delivery, please describe:

____

____

____

Type of Nursery (answer all that apply): Yes No

Well-baby ________

Intensive Care (NICU) ________

If intensive care nursery, please explain: ____

Length of stay in nursery: days (routine? extra days?) _____________________________________

Age child went into a formal childcare situation (day care, home babysitting, etc.) __________

Name of formal childcare situation (day care, home babysitting, etc.) _______________________

Any feedback from caretakers about any concerns about the child? Yes_____ No____

Any problems transitioning from home to daycare/child care/preschool? Yes____ No____

If yes, explain: ____

____

____

What kindergarten did your child attend? ____

How did he/she transition to kindergarten? ____

Did your child begin to learn letter sounds/names at appropriate expectations? Yes___ No____

DIET

Please briefly explain your child's diet, including any allergies ____________________________

____

____

SLEEP

Please briefly explain your child's bedtime and waking routine, including bedtimes _______

____

____

FAMILY HISTORY

Is there a history on Father's side of the child's family of any of the following conditions?

Yes _____No__________ (if yes, see below)

Relationship to child (circle all that apply: parent, sibling, grandparent, aunt, uncle, cousin)

Hyperactivity or AD/HD
Learning Problems
Mental Retardation
Speech or language problems
Severe emotional problem (e.g., depression, schizophrenia, bipolar disorder, etc)
Epilepsy (seizures)
Birth defect
Stillbirths
Alcohol/drug problems
Tics or involuntary movements
Diabetes
Thyroid problem
Hearing loss/problem
Other, specify ________________________________

Is there a history on Mother's side of the child's family of any of the following conditions?

Yes _________ No _________ (if yes, see below)

Relationship to child (circle all that apply: parent, sibling, grandparent, aunt, uncle, cousin)

Hyperactivity or AD/HD
Learning Problems
Mental Retardation
Speech or language problems
Severe emotional problem (e.g., depression, schizophrenia, bipolar disorder, etc)
Epilepsy (seizures)
Birth defect
Stillbirths
Alcohol/drug problems
Tics or involuntary movements
Diabetes
Thyroid problem
Hearing loss/problem
Other, specify _________________________________

PAST MEDICAL HISTORY

Surgeries: Yes_________ No _____

Date ____

Type ____

Hospital name and location ____

Reason____

987 OLD EAGLE SCHOOL ROAD, SUITE 719 • WAYNE, PA • 19087
PHONE: 484.557.5666

Other hospitalizations: Yes _________No____________

Date ____

Hospital name and location ____

Reason ____

Any Head or Brain Injury? Yes_________ No_______

If yes, explain: ____

____

____

Other Accidents or Injuries: Yes _________No _____

Date ________________________________

Type ________________________________

If child is currently taking medications, please list below:

Type of medication _____________________________________

Dose __________________________

Reason ____

Does your child have allergies? Yes _____No ______
If yes, explain: ____

DEVELOPMENTAL HISTORY (age at which your child could do the following or you can use "early" and "late" and "on time" to describe if age is unknown):

Crawl ______________________________________

Coo/babble________________________________

Stand alone _____________________________

Walk alone _____________________________

Single words ___________________________

Phrases/Sentences ________________________________

Toilet trained:__________________________

Toilet__________________________________

Hand preference: Right Left Both Not sure

If your child has difficulty with coloring, fastening or handwriting please explain:
____

Does your child prefer to play (mark any that apply):

_____ Alone
_____With other children (specify)
_____With all ages
_____With same age children
_____With younger children
_____With older children

Do you have any concerns about your child's social skills or play skills? Yes ___ No___

If Yes, please explain:____

____

What does child enjoy doing in his/her spare time?
____

____

EDUCATION (Please answer regardless of child's age or current school)

School district where you live: ____

Name of school and address: ____

Current grade ___________

Teacher's name _______________________________________

Grades repeated, if any: __________________________

Please list any additional service(s) he or she is receiving
____

____

____

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