ATTACHMENT AG

Form Approved
OMB No. 0920-XXXX
Exp. Date xx/xx/20xx

Children's Healthcare of Atlanta Patient History Questionnaire

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DT34544-04

CHILDREN'S HEALTHCARE OF ATLANTA
Department of Neuropsychology

Confidential Patient Questionnaire

IDENTIFYING INFORMATION

Child's Name_____ Date of Birth ___ / ___ / ___

Parents' Names _____

Address _____ Age: _____

_____ Male_____Female_____

Phone _____

Handedness:___right___left___both

Referred by (Who Suggested you have this Evaluation): _____

_____

Reason for Referral (Please describe in detail the problems that are affecting your child and family: _____

_____

Person completing form:_____

Relationship to child:_____ Today's date_____

Diagnosis:_____

PREGNANCY AND NEWBORN HISTORY

Pregnancy: Full term: Yes_____No_____How long?____weeks

Problems during pregnancy:

Medications taken:_____

Illnesses:_____

Bleeding:_____

Smoking:_____

Alcohol:_____

Drugs:_____

Accidents:_____

Unusual circumstances:_____

Number of previous pregnancies_____Child is from pregnancy #_____

Child's birth weight:_____Lbs._____oz.

Labor: Spontaneous_____Induced_____Length of labor_____

Any difficulties_____

Delivery: Vaginal_____C-section_____Explain_____

Forceps_____Apgar scores_____Color_____Jaundice_____

Any complications_____

Special procedures used after birth_____

Special Care Nursery_____Length of stay_____

Other problems_____

(please circle) colic sleeping problems rocking irritability feeding problems excessive crying seizures head banging fevers ear infections

DEVELOPMENTAL HISTORY

At what age did your child:	Age	Problems/Comments
Sit alone	_____	_____
Walk	_____	_____
Crawl	_____	_____
Speak first word	_____	_____
Understand speech	_____	_____
Speak two word sentences	_____	_____
Toilet trained for day	_____	_____
Toilet trained for night	_____	_____
(explain any difficulties)		_____
Previous evaluations	_____	_____
Services provided	_____	_____

	Yes	No
Preschool problems	_____	_____
Academic readiness problems	_____	_____
Fine motor difficulties (i.e. drawing, buttons, zippers)	_____	_____
Gross motor difficulties (i.e. hopping, bike riding)	_____	_____
Difficulty sitting still for t.v. or stories	_____	_____
Difficulty socializing with other children	_____	_____

MEDICAL HISTORY:

Serious falls or injuries? (please describe)_____

Head injuries, seizures, or head trauma?_____

Serious or chronic illnesses during childhood?_____

Hospitalizations, surgeries?_____

Pediatrician_____Other Medical Specialists_____

Current Medications_____ Dosages_____

Past Medications_____ Dosages_____

Medications helpful?_____ In what way?_____

Childhood Illnesses_____

(please circle) meningitis encephalitis otitis media nausea dizziness allergies visual problems stomach aches recurrent headaches asthma

Has your child had any of the following evaluations? Please give the date of, reason for and result of evaluation.

Psychological Problems_____

Psychiatric Assessment (For depression, drug or alcohol abuse, psychoses, etc.)_____

_____

Neurological Evaluations_____

Electroencephalogram (EEG)_____

CT Scan/MRI of the Brain_____

Psychotherapy/Counseling_____

Occupational Therapy_____

Speech/Language Therapy_____

Physical Therapy_____

Hearing/Vision Evaluation_____

Litigation_____

Learning Problems_____

Mental Retardation_____

Genetic_____

EDUCATIONAL BACKGROUND

Current School_____ Grade____ County_____

Preschool_____ Ages Attended_____

Any problems?_____

Kindergarten_____

Any problems?_____

Elementary_____

Any problems?_____

Test scores/reports available_____

Middle School_____

Any problems?_____

Test scores/reports available_____

High School_____

Any problems?_____

Test scores/reports available_____

Suspensions_____ Expulsions_____

Has your child received any of these services?	Yes	No
Early Intervention	_____	_____
Learning disabilities resource	_____	_____
Emotionally handicapped	_____	_____
Intellectually disordered	_____	_____
Self-contained	_____	_____

Speech and language	_____	_____
Tutoring	_____	_____
Physical therapy	_____	_____
Occupational therapy	_____	_____

SOCIAL HISTORY

Mother's name_____Occupation_____

Father's name_____Occupation_____

Years of formal education: Mother_____Father_____

Mother's age_____Father's age_____

Family income: _____under $10,000_____$10,000-$29,999 _____$30,000-$49,000

_____$50,000-$74,999 _____$75,000-$99,999 _____0ver $100,000

Parents are: ___Married ___Separated ___Divorced ___Single ___Widowed

With whom child lives_____

Who lives in the home?_____

Siblings_____Age_____ Grade_____

_____ Age_____ Grade_____

_____ Age_____ Grade_____

_____ Age_____ Grade_____

Significant marital conflict?_____

Significant conflict between parents and child_____

Unusual behaviors/tics_____Types of discipline_____

Child's response_____

Difficulty getting along with adults_____

Hobbies_____

Peer relationships_____

Any sudden changes in behavior_____

Strengths_____

Weaknesses_____

Organizations child belongs to_____

Significant Family Information: (including child's parents, grandparents, aunts, uncles, and cousins) Please provide as much detail as possible:

Psychological Problems_____

Psychiatric Assessment (For depression, drug or alcohol abuse, psychoses, etc.)_____

_____

Neurological Evaluations_____

Electroencephalogram (EEG)_____

CT Scan/MRI of the Brain_____

Psychotherapy/Counseling_____

Financial Stress_____

Litigation_____

Learning Problems_____

Mental Retardation_____

Genetic_____