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____