CNS MEMORY CLINIC
Comprehensive Neuropsychological Services

PEAK PERFORMANCE INSTITUTE
UPGRADE YOUR BRAIN

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PPI / Children Phone (623) 440-5053 • 2440 N. Litchfield Road, Suite 206 • www.peakperformancebrain.com

Developmental and Medical History

Patient Name: **M / F** **Education:**

Date of Birth (Age): **( )** **Handedness:**

Primary Care Physician:

Neurologist / Other:

Other Provider:

Form Filled Out By: **Home Language:**

Home Address:

Contact Number: (home, work, cell)

Family History

Is this child adopted or a foster child? _____

Are parents married? Yes ☐ / No ☐ Divorced? Yes ☐ / No ☐

If divorced or separated, who has legal custody of the child? _____

(In the case of joint custody following divorce, all parents/ guardians with legal custody must sign forms consenting to the evaluation.)

Parent / Caregiver's Education: _____ Occupation: _____

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ABOUT YOUR CHILD

Chief problem or concern: _____

_____

_____

_____

Comprehensive Assessment of: Memory Loss – Mild Cognitive Impairment (MCI) – Alzheimer's Disease – Dementias (e.g., Vascular) – Postconcussional Syndrome (PCS) – Traumatic Brain Injury (TBI) – Transient Ischemic Attack (TIA) – Stroke & Recovery – Competency Evaluations – Neurodegenerative Disease (e.g., ALS, Multiple Sclerosis, Parkinson's) – Forensic Evaluations – Attention Deficit Disorder (ADD) – Intelligence (IQ) Testing & Learning Disorders (e.g., Dyslexia, Dysgraphia, Reading and Math Learning Disorders – Autism Spectrum Evaluations – Selective Mutism – Conduct and Oppositional Defiant Disorder – Anxiety, Depression, Bipolar, OCD, PTSD, and other Psychological Assessments – Post COVID-19 Cognitive Loss – Surgical Candidates (e.g., SCS, gastric)

Has child been previously evaluated? (If yes list dates & evaluators)

_____

What were the results / recommendations? _____

_____

_____

Has child received any supportive services such as tutoring, mental health treatment, occupational therapy, ABA? (If yes by who, between what dates, and why?)

_____

_____

Please describe any history of trauma and / or significant changes or disruptions in this child's life, as well as what age it occurred: _____

_____

_____

Is there a history or current sensory-based concerns? (tactile, loud noises, tastes, etc.)

_____

_____

PREGNANCY AND DELIVERY

A. Length of pregnancy (e.g., full term, 40 weeks, 32 weeks, etc.) _____

B. Length of delivery (number of hours from initial labor pains to birth) _____

C. Mother's age when child was born _____

D. Child's birth weight _____

E. Condition at birth _____

F. Did any of the following occur during pregnancy/delivery? *(check if it applies)*

1. Bleeding ☐
2. Excessive weight gain (more than 30 lbs.) ☐
3. Toxemia/preeclampsia ☐
4. Rh factor incompatibility ☐
5. Frequent nausea or vomiting ☐
6. Serious illness or injury ☐
7. Took prescription medications ☐

   if yes, name of medication _____

8. illegal drugs ☐
   if yes, name of drugs _____
   how often taken _____
9. alcoholic beverages ☐
   if yes, approximate number of drinks per week _____
10. Smoked cigarettes ☐
    if yes, approximate number of cigarettes per day (e.g., ½ pack) _____
11. Was given medication to ease labor pains ☐
    if yes, name of medication _____
12. Delivery was induced ☐
13. Forceps were used during delivery ☐
14. Had a breech delivery ☐
15. Had a cesarean section delivery ☐
16. Other problems-please describe

_____

_____

G. Did any of the following conditions affect your child during delivery or within the first few days after birth? *(Check if it applies)*

1. Injured during delivery ☐
2. Cardiopulmonary distress during delivery ☐
3. Delivered with cord around neck ☐
4. Had trouble breathing following delivery ☐
5. Needed oxygen ☐
6. Was cyanotic, turned blue ☐
7. Was jaundiced, turned yellow ☐
8. Had an infection ☐
9. Had seizures ☐
10. Was given medications ☐
11. Born with a congenital defect ☐
12. Was in hospital more than 7 days ☐

INFANT HEALTH AND TEMPERAMENT

A. During the first 12 months, was your child: *(Check if it applies)*

1. Difficult to feed ☐
2. Difficult to get to sleep ☐
3. Colicky ☐
4. Difficult to put on a schedule ☐
5. Alert ☐
6. Cheerful ☐
7. Affectionate ☐
8. Sociable ☐
9. Easy to comfort ☐
10. Difficult to keep busy ☐
11. Overactive, in constant motion ☐
12. Very stubborn, challenging ☐
13. Any other infant problems—please describe _____

EARLY DEVELOPMENTAL MILESTONES

A. At what age did your child first accomplish the following:

1. Sitting without help _____
2. Crawling _____
3. Stood alone _____
4. Walking alone, without assistance _____
5. Using single words (e.g., "mama," "dada," "ball," etc.) _____
6. Putting two or more words together (e.g., "mama up") _____
7. Bowel training, day, and night _____
8. Bladder training, day, and night _____
9. Show hand preference (which hand) _____
10. Fed self _____

HEALTH HISTORY

A. Date of child's last physical exam: _____

B. At any time has your child had the following: *(Check if it applies)*

1. Asthma ☐
2. Allergies ☐
3. Diabetes, arthritis, or other chronic illnesses ☐
4. Epilepsy or seizure disorder ☐
5. Febrile seizures ☐
6. Chicken pox or other common childhood illnesses ☐
7. Heart or blood pressure problems ☐
8. High fevers (over 103 degrees) ☐
9. Broken bones ☐
10. Severe cuts requiring stitches ☐
11. Head injury with loss of consciousness ☐
12. Lead poisoning ☐
13. Surgery ☐
14. Lengthy hospitalization ☐
15. Speech or language problems ☐
16. Chronic ear infections ☐
17. Hearing difficulties ☐
18. Eye or vision problems ☐
19. Fine motor/handwriting problems ☐
20. Gross motor difficulties, clumsiness ☐
21. Appetite problems (over / under eating) ☐
22. Sleep problems (falling asleep, staying asleep) ☐
23. Soiling problems ☐
24. Wetting problems ☐
25. Headaches ☐
26. Other health difficulties please describe

_____

_____

PHYSICAL SYMPTOMS:

Does your child…

- have any difficulties with smell (Olfaction)?
- have any difficulties with taste (Gustation)?
- have any difficulties walking smoothly (Gait)?
- trip and fall often (Fall)?
- tire out quickly or easily (Fatigue)?
- have balance issues like being clumsy, overall (Balance/Dizziness)?
- experience any Unusual Loss of Strength? (*If yes, where?)*
- spill or drop things often (Coordination Problems)?

ACTIVITIES OF DAILY LIVING (ADLS) / COMPETENCY:
(if over 12 years of age):

Medications: Does your child have any difficulties remembering to take medications?

Math Problems/Financial: Does your child spend money they earn impulsively?

Food Preparation/Eating: Does your child have any difficulties with helping prepare a meal?

Self-Care/Hygiene: Does your child need reminders for showers?

Incontinence: Does your child have trouble getting to the bathroom on time?

- [bladder] Do they wet their pants?
- [bowel] Do they have bowel movements/accidents?

Driving: Does your child drive? *If so,* are they having any trouble with this?

DISCINIPLINARY ACTIONS OR LEGAL TROUBLE:

- Has your child ever been Suspended/Expelled from school?
- Are they trying to get Services?
- Are they a Disability Applicant?
- Any there any Legal Charges against them?

Is this child currently on any medications?
If yes, what medications, current dose for each, and who is the prescriber?

_____

_____

_____

Please describe child's strengths: _____

_____

_____

Please describe child's weaknesses: _____

_____

_____

What are your child's favorite activities? _____

_____

What is your child's least favorite activities? _____

_____

Are there behavioral problems at home or school and when did they first begin?

_____

_____

How would you characterize your child's relationship(s) with their sibling(s)? _____

_____

_____

_____

What is your child's relationship like with you as well as this child's other parent(s)?

_____

_____

_____

Please describe your child's ability to wake in the morning and prepare for the day:

_____

_____

On average, how often, does your child comply with an initial command/directive?
Please describe. _____

_____

How does your child respond to criticism or redirection? _____

_____

SCHOOL HISTORY

Present Grade: _____ Has child repeated a grade? _____
Did this child attend preschool? ☐ Yes / No ☐
Name of school: _____
School address: _____
School contact person: _____ Phone number: _____
May I contact this person regarding your child's schoolwork? ☐ Yes / No ☐

Any difficulty with early school skills? (colors, counting, alphabet) _____

When did school problems become evident? _____

_____

Has your child been evaluated for special educational services, accommodations, or an Individualized Education Plan (IEP) or 504 Plan through the school? _____

Does your child enjoy school? _____

How would you describe your child's relationships/interactions with their peers?

_____

_____