KRISTEN HERZEL, PH.D.
PEDIATRIC NEUROPSYCHOLOGY
LICENSED PSYCHOLOGIST # PS 009271-L
PA CERTIFIED SCHOOL PSYCHOLOGIST #02039315
OFFICE ADDRESS: 13 WEST THIRD ST., MEDIA, PA 19063
MAILING ADDRESS: 103 CORNELL AVE., SWARTHMORE, PA 19081
PHONE: (610) 541-0710

History Questionnaire

Child's Name:_____ Today's Date: _____

Child's Date of Birth: _____Child's Age: _____ Grade in School: _____

Parent's Names: _____

Home Address: _____Zip:_____

Telephone Numbers: (home) _____ (work) _____

Name of person completing questionnaire: _____

Relationship to child: _____

Who referred the child? _____

Name of School: _____ School District: _____

Teacher(s) Names: _____

Is your child currently designated a special education student? _____

Under what exceptionality/disability? _____

Does your child receive speech/occupational therapy? _____ How often? _____

Does your child go to resource room/learning support? _____ How often? _____

Please list any previous diagnoses:

Diagnosis	**When was it made?**	**By whom?**

When was your child's most recent school district/Early Intervention evaluation? _____

Please list the major concerns that had you bring your child to be evaluated:

_____

_____

_____

_____

_____

_____

Please describe your child's strengths: _____

_____

_____

_____

FAMILY HISTORY

Is your child: biological adopted foster child other

Are his/her parents: unmarried separated divorced married other

With whom does the child live? (please include all household members, including parents, siblings, grandparents, foster children, roommates): _____

_____

What language (s) is/are used at home? _____

Mother's level of education: _____Father's: _____

Mother's occupation: _____ Father's: _____

Do any family members have a history of any of the following:

PROBLEM	FAMILY MEMBER AND RELATIONSHIP TO CHILD
Ambidextrousness	
Behavior problems	
Attention deficit disorder	
Poor school performance	
Speech articulation problems	
Language delay	
Dyslexia/reading problem	
Mental retardation or developmental delay	
Epilepsy or seizures	
Cerebral palsy	
Autism/pervasive developmental disorder	
Anxiety or depression	
Mental illness	

PREGNANCY AND BIRTH HISTORY:

Was this pregnancy monitored at regular intervals by a physician or midwife? _____

Were there any complications during the pregnancy with your child? _____

_____

How were they treated? _____

Did biological mother smoke cigarettes? _____Drink alcohol? _____ Use drugs?_____

_____

Length of pregnancy _____Apgar scores (if known) _____Birthweight_____

Was labor: spontaneous induced Reason if induced: _____

Was delivery: vaginal C-section Reason if C-section: _____

Did the child require: forceps vacuum extraction resuscitation at birth?

Did the child experience any of the following? Rh incompatibility jaundice

Were there any other complications at delivery, birth, or in the newborn period? _____

_____

_____

Child's Medical History:

Has your child ever had any of the following (please describe, including dates, diagnostic studies, and treatments to date)

Seizures/convulsions (type, frequency, duration) _____

Meningitis or encephalitis? _____

Surgery _____

Hospitalizations _____

Head injuries _____

Allergies _____

Frequent ear infections _____

Placement of PE tubes in ears? _____

List the child's medications and daily dosages: _____

When was your child's vision last tested? _____ By whom? _____

Results: _____ Does your child wear eyeglasses? _____

When was your child's hearing last tested? _____ By whom? _____

Results: _____ Does your child wear a hearing aid? _____

When was your child's last visit to the pediatrician? _____

Child's Developmental History:

Describe your child's temperament in infancy:_____

Was s/he easily soothed? _____

Did s/he respond to cuddling? _____

At what age did your child say first word? _____ Two words together? _____

Speak in sentences? _____ When was s/he first easily understood by strangers? _____

Was your child's understanding of language similar to others his/her age?_____

When did your child first sit by him/herself? _____

Crawl? _____ Stand? _____ Walk? _____ Run? _____

Does your child show a hand preference? ____For which hand? _____ When did this begin? _____

Was your child's development delayed in any way? In what way? _____

_____

When did you first become concerned? _____

Did you consult a professional? Who was it? _____

What was recommended? _____

Was the child evaluated (please give details: at what age, by whom, results/recommendations)? ____

_____

Did your child receive Early Intervention services as an infant/toddler? _____

Why was your child considered eligible for services? _____

_____

Please list types of therapies, start and end dates, and weekly frequencies: _____

_____

Preschool History: Please describe the type of preschool your child attended and any outstanding areas of strength or difficulty s/he encountered:

Preschool	Dates attended	Strengths/issues	Teachers name

School History:

Please list the elementary school(s) your child has attended, with beginning and ending dates:

School	Dates attended	Strengths/issues	Teachers name

Describe your child's adjustment to kindergarten (with behavioral, social, and academic expectations)

_____

_____

Did your child have difficulty with learning the alphabet and with early reading? _____

_____

Math? _____

Did s/he receive any extra help? _____ What kind? _____

When did you first notice a problem? _____

Describe the problems noted then: _____

Have there been any difficulties with adjustment/behavior/academic expectations/social interaction at school (please describe):

_____

_____

_____

_____

_____

_____

Has your child's teacher noted any difficulties that you have not described above? _____

_____

What is your plan for your child's next school year (or what options are you considering)? _____

_____

Describe your child's strengths at school: _____

_____

_____

_____

_____

Current Functioning at Home:

Do you have any concerns about your child's behavior at home? Please describe them: _____

_____

_____

_____

_____

_____

_____

Have you sought the assistance of a psychologist/ therapist/ counselor to help with behavior? _____

If so, who was it? Describe frequency/ duration. Was it helpful? _____

_____

_____

_____

How is your child disciplined? _____ How well does it work? _____

Any concerns about your child's eating habits? _____

Sleeping habits? _____

Describe your child's usual play choices: _____

_____

_____

_____

Does your child play with other children in the neighborhood? _____

Have play dates with friends from school? _____

Is there any current, unusual marital/family/family health stress that might be affecting your child?

_____

_____

_____

Previous Evaluations

Has your child had any of the following evaluations? Please list dates, names of professionals, and test results:

Evaluation	Date	Results
Speech/Language		
Occupational Therapy		
Physical Therapy		
Developmental Evaluation		
Psychological Evaluation		
Neuropsychological Evaluation		
School Testing		
CT scan		
MRI scan		
EEG		
Neurological Evaluation		

Comments:

Please add any helpful comments, information, or concerns that you have not listed above. _____

_____

_____

_____

_____

_____

_____

Thank you.