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# Cognitive/Academic/Neuropsychological History Form

Client's name ______________________________ Date ______________

Age ________ Birthdate ________ Religion ____________________ Sex ________

Hand client uses for writing / drawing: Right ____ Left ____ Switches ______

Mother's handedness RT or LFT    Father's handedness RT or LFT

Primary language ____________________ Secondary language ______________

Medical diagnosis, if any (1) ________________________________
(2) ________________________________

Describe the problems, first major concerns and then minor ones. ______________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**THIS FORM HAS BEEN COMPLETED BY:**

Name ____________________________ Relationship to client ______________

Phone Number________________________

## SYMPTOM SURVEY

For each symptom that applies to the client, place a check in the box. Compare the (client, child, partner, or you) to other people of the same age. Then, check if this is a NEW symptom (within the past year) or an OLD symptom (over one year). Add any helpful comments next the item.

### 1) PROBLEM SOLVING

| √ | New | Old | |
|---|---|---|---|
| □ | ___ | ___ | Difficulty figuring out how to do new things |
| □ | ___ | ___ | Difficulty making decisions |
| □ | ___ | ___ | Difficulty solving problems a others can |
| □ | ___ | ___ | Difficulty understanding explanations |
| □ | ___ | ___ | Difficulty doing things in the right order (sequencing) |
| □ | ___ | ___ | Difficulty verbally describing the steps involved in doing something |
| □ | ___ | ___ | Difficulty completing an activity in a reasonable period of time |
| □ | ___ | ___ | Difficulty changing a plan or activity when necessary |
| □ | ___ | ___ | Slow to learn new things |
| □ | ___ | ___ | Difficulty switching from one activity to another activity |
| □ | ___ | ___ | Easily frustrated |
| □ | ___ | ___ | Other problem solving difficulties ______________________________ |

### 2) SPEECH, LANGUAGE, AND MATH SKILLS

| √ | New | Old | |
|---|---|---|---|
| □ | ___ | ___ | Difficulty speaking clearly |
| □ | ___ | ___ | Difficulty finding the right word to say |
| □ | ___ | ___ | Rarely talks |
| □ | ___ | ___ | Rambles on and on without saying much |
| □ | ___ | ___ | Jumps from topic to topic |
| □ | ___ | ___ | Odd or unusual language or vocal sounds |
| □ | ___ | ___ | Difficulty understanding what others are saying |
| □ | ___ | ___ | Difficulty understanding what he/she is reading |
| □ | ___ | ___ | Difficulty writing letters or words |
| □ | ___ | ___ | Difficulty reading letters or words |
| □ | ___ | ___ | Difficulty with spelling |
| □ | ___ | ___ | Difficulty with math |
| □ | ___ | ___ | Other speech, language, or math problems: ________________ |

### 3) SPATIAL SKILLS

| √ | New | Old | |
|---|---|---|---|
| □ | ___ | ___ | Confusion telling right from left |
| □ | ___ | ___ | Has difficulty with puzzles, Legos, blocks, or similar games |
| □ | ___ | ___ | Problems drawing or copying |
| □ | ___ | ___ | Doesn’t know his/her colors |
| □ | ___ | ___ | Difficulty dressing (not due to physical difficulty) |
| □ | ___ | ___ | Problems finding his/her way around places he/she has been to before |
| □ | ___ | ___ | Difficulty recognizing objects |
| □ | ___ | ___ | Seems unable to recognize facial or body expressions of emotions |

□ ___ ___ Gets lost easily
□ ___ ___ Other visual or spatial problems: ________________________________________

4) **AWARENESS AND CONCENTRATION**

√ New Old
□ ___ ___ Easily distracted by: Sounds ___ Sights ___ Physical sensations __
□ ___ ___ Mind appears to go blank at times
□ ___ ___ Loses train of thought
□ ___ ___ Difficulty concentrating on what others say, but can sit in front of a TV for long periods
□ ___ ___ Attention starts out OK but can't maintain it
□ ___ ___ Other attention or concentration problems: ________________________

5) **MEMORY**

√ New Old
□ ___ ___ Forgets where he/she/I leave(s) things
□ ___ ___ Forgets things that happened recently (e.g., last meal)
□ ___ ___ Forgets things that happened days/weeks ago
□ ___ ___ Forgets what he/she/I is(am) supposed to be doing
□ ___ ___ Forgets names more than most people do
□ ___ ___ Forgets to complete school/job tasks
□ ___ ___ Forgets instructions
□ ___ ___ Other memory problems: ________________________________________

6) **MOTOR AND COORDINATION**

| √ | New | Old | | Check if this occurs on: Right | Left | Both |
|---|---|---|---|---|---|---|
| □ | ___ | ___ | Poor fine motor skills (e.g., using a pen or pencil) | _____ | _____ | _____ |
| □ | ___ | ___ | Clumsy | _____ | _____ | _____ |
| □ | ___ | ___ | Weakness | _____ | _____ | _____ |
| □ | ___ | ___ | Tremor | | | |
| □ | ___ | ___ | Muscles are tight or spastic | _____ | _____ | _____ |
| □ | ___ | ___ | Odd movements (posturing, peculiar hand movements, etc.) | | | |
| □ | ___ | ___ | Drops things more than most individuals | | | |
| □ | ___ | ___ | Has an unusual walk | | | |
| □ | ___ | ___ | Balance problems | | | |
| □ | ___ | ___ | Other motor or coordination problems: ________________________________________ | | | |

7) **SENSORY**

| √ | New | Old | | check the side this occurs on: Right | Left | Both |
|---|---|---|---|---|---|---|
| □ | ___ | ___ | Needs to squint or move closer to page to read | | | |
| □ | ___ | ___ | Problems seeing objects | _____ | _____ | _____ |
| □ | ___ | ___ | Loss of feeling | _____ | _____ | _____ |
| □ | ___ | ___ | Problems hearing sounds | | | |
| □ | ___ | ___ | Difficulty telling hot from cold | | | |
| □ | ___ | ___ | Difficulty smelling odors | | | |
| □ | ___ | ___ | Difficulty tasting food | | | |

☐ ___ ___ Overly sensitive to: Touch____ Light____ Noise_____
☐ ___ ___ Other sensory problems:________________________________________

8) **PHYSICAL**

| √ | New | Old | | How often? |
|---|---|---|---|---|
| ☐ | ___ | ___ | Frequently complains of headaches or nausea | ____________ |
| ☐ | ___ | ___ | Has dizzy spells | ____________ |
| ☐ | ___ | ___ | Has pains in joints Where?_________________________ | ____________ |
| ☐ | ___ | ___ | Excessive tiredness | ____________ |
| ☐ | ___ | ___ | Frequent urination or drinking | ____________ |
| ☐ | ___ | ___ | Other physical problems: _________________________ | ____________ |

9) **BEHAVIOR**

| √ | New | Old | | √ | New | Old | |
|---|---|---|---|---|---|---|---|
| ☐ | ___ | ___ | Aggressive | ☐ | ___ | ___ | Nervous |
| ☐ | ___ | ___ | Attached to things, not people | ☐ | ___ | ___ | Quiet |
| ☐ | ___ | ___ | Bedwetting | ☐ | ___ | ___ | Unmotivated |
| ☐ | ___ | ___ | Bizarre behavior | ☐ | ___ | ___ | Resists change |
| ☐ | ___ | ___ | Bowel movements in underwear | ☐ | ___ | ___ | Risk-taking |
| ☐ | ___ | ___ | Dependent | ☐ | ___ | ___ | Self-mutilates |
| ☐ | ___ | ___ | Depressed | ☐ | ___ | ___ | Self-stimulates |
| ☐ | ___ | ___ | Eating habits are poor | ☐ | ___ | ___ | Shy and withdrawn |
| ☐ | ___ | ___ | Emotional | ☐ | ___ | ___ | Sleeping habits are poor |
| ☐ | ___ | ___ | Fearful | ☐ | ___ | ___ | Swears a lot |
| ☐ | ___ | ___ | Immature | ☐ | ___ | ___ | Nightmares, night terrors, sleepwalks |

☐ ___ ___ Other unusual behavior: ______________________________________

Below, circle the number that best describes your (client's, child's, partner's, own) behavior and has been present for at least the **past 6 months**. 0 = Never or very rarely, 1= Sometimes, 2= Often, 3= Very often or almost always.

| | | | | |
|---|---|---|---|---|
| Fails to give close attention to details or makes careless mistakes……………… ………... | 0 | 1 | 2 | 3 |
| Has difficulty sustaining attention in tasks or activities ….………………………………….. | 0 | 1 | 2 | 3 |
| Does not seem to listen when spoken to directly ………………………………………… | 0 | 1 | 2 | 3 |
| Does not follow through on instructions and fails to finish work ………………………... | 0 | 1 | 2 | 3 |
| Has difficulty organizing tasks and activities …………………………………………….. | 0 | 1 | 2 | 3 |
| Avoids tasks (e.g., schoolwork, pay bills) that require mental effort ……………………… | 0 | 1 | 2 | 3 |
| Loses things necessary for tasks or activities …………………………………………….. | 0 | 1 | 2 | 3 |
| Is easily distracted ………………………………………………………………………... | 0 | 1 | 2 | 3 |
| Is forgetful in daily activities ……………………………………………………………... | 0 | 1 | 2 | 3 |
| Fidgets with hands or feet or squirms in seat ……………………………………………... | 0 | 1 | 2 | 3 |
| Leaves seat in situations in which remaining seated is expected …..…..…..…..…..…..….. | 0 | 1 | 2 | 3 |
| Runs about or climbs excessively in situations in which it is inappropriate ................….. | 0 | 1 | 2 | 3 |
| Has difficulty playing or engaging in leisure activities quietly …………………………… | 0 | 1 | 2 | 3 |
| Is "on the go" or act as if "driven by a motor" …………………………………………… | 0 | 1 | 2 | 3 |
| Talks excessively ………………………………………………………………………….. | 0 | 1 | 2 | 3 |
| Blurts out answers before questions have been completed …………………………….. | 0 | 1 | 2 | 3 |

| | | | | |
|---|---|---|---|---|
| Has difficulty awaiting turn ………… | 0 | 1 | 2 | 3 |
| Interrupts or intrudes on others ………… | 0 | 1 | 2 | 3 |
| Loses temper ………… | 0 | 1 | 2 | 3 |
| Argues with others ………… | 0 | 1 | 2 | 3 |
| Actively defies or refuses to comply with behavioral requests or rules ………… | 0 | 1 | 2 | 3 |
| Deliberately annoys people ………… | 0 | 1 | 2 | 3 |
| Blames others for his/her mistakes or misbehaviors ………… | 0 | 1 | 2 | 3 |
| Is touchy or easily annoyed by others ………… | 0 | 1 | 2 | 3 |
| Is angry and resentful ………… | 0 | 1 | 2 | 3 |
| Is spiteful or vindictive ………… | 0 | 1 | 2 | 3 |

Below, check all the descriptions of the client that have been present for at least the past 12 months. These behaviors should occur more frequently than in other individuals of the same age:

___ Steals things without people knowing on several occasions
___ Easily lies to others
___ Is often rude
___ Starts fights with others
___ Firesetting
___ Rarely follows others' instructions
___ Breaks into other people's property
___ Is cruel to animals
___ Is cruel to other people
___ Destroys other people's property
___ Frequently does dangerous things without considering the consequences

10) Overall, the client's symptoms have developed: ___ Slowly ___ Quickly

11) The symptoms occur: ___ Occasionally ___ Often

12) Over the past 6 months the symptoms have: ___ Stayed about the same ___ Worsened

**PREGNANCY**

13) Mother's age at client's birth:________________ Father's age at client's birth:______________

14) **Before** the pregnancy, what medications (prescribed or over-the-counter) did the mother take?
List all medications used:________________________________________________________________

15) **While** pregnant, what medications (prescribed or over-the-counter) did the mother take?
List all medications used:________________________________________________________________

16) How often did the mother see her doctor during the pregnancy?
Regularly (as scheduled by the doctor)_____ Rarely______ Not at all______

17) During the pregnancy, which of the following did the mother use?

| | **Amount and Daily Frequency** |
|---|---|
| ______ Alcohol | ________________________________________ |
| ______ Caffeine (coffee, colas, etc.) | ________________________________________ |

______ Marijuana ________________________________________
______ Recreational drugs (cocaine, heroin, etc.) ________________________________________
______ Tobacco ________________________________________

18) During the pregnancy, the mother's diet was: Good _______ Poor ________
If poor, explain:______________________________________________________________________

19) The mother's general physical health during the pregnancy was: Good ______ Poor ________
If poor, explain:________________________________________________________________________

20) About how much weight did the mother gain while she was pregnant? ____________ lbs.

21) During this pregnancy, check all the mother had:

_________ Accident
_________ Anemia
_________ Bleeding (severe or frequent spotting)
_________ Preeclampsia, eclampsia, or toxemia
_________ Surgery
_________ Diabetes
_________ High blood pressure
_________ Illnesses or infections
_________ Psychological problems
_________ Vomiting (severe or frequent)

22) How many pregnancies did the mother have prior to this one?
Number of live births: _________
Number of miscarriages: _________

**BIRTH**

23) Was this client born:

| | | |
|---|---|---|
| Early | ___ | How early? ________ weeks |
| On time | ___ | (38 - 42 weeks) |
| Late | ___ | How late? ________ Weeks |

24) How much did the client weigh at birth? ______ lbs. ______ oz. OR ______ gms.

25) How long did the labor last? ____________________________________________________

26) The labor was: Easy _______ Moderately difficult ________ Very difficult _______

27) What type of medication was the mother given to help with delivery? None______
Demerol _____Gas _____ Regional nerve (spinal) block _____ Tranquilizer _____ Epidural _____

28) Were forceps used during delivery? Yes ________ No ________

29) Was the client born:

| | | |
|---|---|---|
| Head first _____ | Transverse (crosswise) _____ | Posterior first _____ |
| Breech birth _____ | Caesarean section _____ | Vacuum extraction _____ |

Other: ______________________________________________________________________

30) Did the client experience any of these problems:
Fetal distress _____ Low placenta (Placenta previa) _____ Prolapsed cord _____
Premature separation of placenta (Abruptio placenta) _____ Cord wrapped around neck _____

31) Describe any other special problems the mother or client had during delivery:
______________________________________________________________________________
______________________________________________________________________________

32) At birth, did the client:

| | | |
|---|---|---|
| Have difficulty breathing? | Yes _____ | No _____ |
| Fail to cry? | Yes _____ | No _____ |
| Appear inactive? | Yes _____ | No _____ |

33) List the client's Apgar scores: 1st _________ 2nd _________

34) If the father or mother noticed anything unusual when they first saw the client, please describe:
______________________________________________________________________________

35) If the client was born with any problems (congenital defects, large or small head, blue client, bleeding in brain, etc.), please describe: ______________________________________________
______________________________________________________________________________

36) Describe any special problems that the client had in the first few days following birth:
______________________________________________________________________________

37) Describe any special care, treatment, or equipment the client was given after birth:
______________________________________________________________________________

38) How long did the client stay in the hospital? _________________________________________

## DEVELOPMENTAL HISTORY

For each area, indicate the client's (or your) health by circling one description. The "Average" period is only a rough idea of what is average since every developmental milestone actually involves a range of several months (e.g., walking occurs approximately 9-18 months of age). Circle "Early" or "Late" only if you are sure the client's development was different from that of most other children.

**GROSS MOTOR SKILLS**

| | | | |
|---|---|---|---|
| Crawled | Early | Average (6-9 months) | Late |
| Walked alone (2-3 steps) | Early | Average (9-18 months) | Late |

**LANGUAGE**

| | | | |
|---|---|---|---|
| Followed simple commands | Early | Average (12-18 months) | Late |
| Used single-word sentences | Early | Average (12-24 months) | Late |

**SELF-HELP**

| | | | |
|---|---|---|---|
| Toilet trained | Early | Average (13-36 months) | Late |

40) List any other significant developmental problems:____________________________________________
______________________________________________________________________________

41) Overall, the client's development was: Early _______ Average _______ Late _______

42) As an infant or toddler, did the client have poor muscle control (i.e., weakness) of the:
Neck _______ Trunk _______ Legs _______ Arms _______

43) As an infant or toddler, did the client's muscles seem to be unusually tight or stiff?
Yes _____ No _____ If yes, describe:__________________________________________________

44) Toilet training was: Easy _______ Difficult _______

45) As an infant or toddler, the client was:

| | |
|---|---|
| Too calm and inactive | _______ |
| Calm and reasonably active | _______ |
| Irritable and very active | _______ |

46) As a toddler, the client was:

| | |
|---|---|
| Shy and inhibited | _______ |
| Neither shy nor outgoing | _______ |
| Very outgoing and like people | _______ |

## HEALTH HISTORY

47) Did the client have a poor appetite as a child? Yes _____ No _____

48) Did the client fail to gain weight steadily as a child? Yes _____ No _____

49) List the client's illnesses or physical problems during the first year:____________________________
______________________________________________________________________________

50) Has the client had a temperature of 104°F (40°C) or higher for more than a few hours?
Yes _____ No _____ If yes, what age(s)? __________ and how long did it last ___________

51) Has the client ever been hit hard on the head or suffered a head injury? Yes _____ No ____
If yes, what age(s)? ___________ Did the client lose consciousness? Yes _____ No ____
How did it happen? ________________________________________________________
What problems did the client have (physical or mental) afterwards? _______________________
__________________________________________________________________________
__________________________________________________________________________

Did the client ever have a seizure due to a fever or unknown cause? Yes ____ No ____
If yes, describe (age, nature of seizure): __________________________________________

52) Has the client been diagnosed with seizures or epilepsy? Yes _____ No ____
If yes, which type? Partial seizure _____ Generalized seizure _____ Unclassified type ____
If medication is used, what medication(s)? _________________________________________
Has the client ever had a bad reaction to this medication? Yes _____ No ____
If yes, describe: ______________________________________________________________

53) Was the client ever in the hospital for an accident, injury, or operation? Yes _____ No ____
If yes, what age(s)? _______ What happened? ___________________________________

54) Has the client ever swallowed any poison, non-food, or drug accidentally? Yes _____ No ____
If yes, what age(s)? _______ What happened: ___________________________________

55) Did the client have frequent ear infections? Yes _____ No ____
If yes, what age(s)? _______ How often and severe? ______________________________
What treatment was provided? ____________________________________________________

56) Please check all the following diseases or conditions the client has ever had:

| | | | |
|---|---|---|---|
| ____ Allergies | ____ Cerebral palsy | ____ Jaundice | ____ Mumps |
| ____ Anemia | ____ Chicken pox | ____ Kidney disorder | ____ Oxygen deprivation |
| ____ Asthma | ____ Colds (excessive) | ____ Leukemia | ____ Pneumonia |
| ____ Bleeding disorder | ____ Diabetes | ____ Liver disorder | ____ Rheumatic fever |
| ____ Blood disorder | ____ Encephalitis | ____ Lung disorder | ____ Scarlet fever |
| ____ Brain disorder | ____ Enzyme deficiency | ____ Measles | ____ Tuberculosis |
| ____ Broken bones | ____ Genetic disorder | ____ Meningitis | ____ Venereal disease |
| ____ Cancer | ____ Heart disorder | ____ Metabolic disorder | ____ Whooping cough |

____ Other problems: ______________________________________________________________

57) As the client grew up, he/she had been sick:
Much of the time ______ An average amount ______ Not much at all _____

58) List all medication the client takes now:

| **Medication** | **Dosage** | **How often?** | **What for?** |
|---|---|---|---|
| __________________ | _______________ | ________________ | __________________ |
| __________________ | _______________ | ________________ | __________________ |
| __________________ | _______________ | ________________ | __________________ |
| __________________ | _______________ | ________________ | __________________ |
| __________________ | _______________ | ________________ | __________________ |
| __________________ | _______________ | ________________ | __________________ |
| __________________ | _______________ | ________________ | __________________ |
| __________________ | _______________ | ________________ | __________________ |

59) Does the client:
Wear glasses? Yes_____ No_____ (Farsighted_____ Nearsighted _____ Other_____)
Use a hearing aid? Yes_____ No_____

60) Within the past year, has the client had: **Results**
A vision test? Yes_____ No_____ ____________________________
A hearing test? Yes_____ No_____ ____________________________

61) What is the client's: Height ______ft. ______ in. Weight ________lbs.

62) When was the client's last medical check-up?
__________________________________________________

63) What therapies have been provided to the client? _________ No Therapies

_______ Occupational therapy
_______ Physical therapy
_______ Psychological therapy, counseling, or cognitive rehabilitation
_______ Speech therapy
_______ Other therapy: _______________________________________________________________

## PSYCHIATRIC HISTORY

**Outpatient Treatment** ( ) Yes ( ) No If yes, please provide information about diagnoses and treatment.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Psychiatric Hospitalization** ( ) Yes ( ) No If yes, please provide information about diagnoses and treatment.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Family Psychiatric History**

Has anyone in your family been diagnosed with or treated for:

| | | | | | |
|---|---|---|---|---|---|
| Bipolar disorder | ( ) Yes ( ) No | Schizophrenia | ( ) Yes ( ) No | Depression | ( ) Yes ( ) No |
| PTSD | ( ) Yes ( ) No | Anxiety | ( ) Yes ( ) No | Alcohol abuse | ( ) Yes ( ) No |
| Anger | ( ) Yes ( ) No | Suicide | ( ) Yes ( ) No | Violence | ( ) Yes ( ) No |

## SUBSTANCE USE HISTORY

| **Please list substances you have used and complete the chart for each.** | | | | |
|---|---|---|---|---|
| **Substance** | **First Use** | **Last Use** | **Frequency/ Amount** | **Do you consider your usage to be a problem, currently?** |
| **Alcohol** | | | | |
| **Cannabis** | | | | |
| **Prescription Drugs (abuse)** | | | | |
| **Other (please specify)** | | | | |
| **Other (please specify)** | | | | |
| **Other (please specify)** | | | | |

_______________________________________________________________________________

| Please list your favorite substance and an explanation about what you like about it. |
| --- |
| |

Has anyone in the client's biological family (including parents, grandparents, siblings, cousins, aunts & uncles) ever had substance use problems:

| **Substance** | **If comfortable, please provide family member(s)** |
| --- | --- |
| __Alcohol | ______________________________________________ |
| __Cannabis | ______________________________________________ |
| __Other:___________ | ______________________________________________ |
| __Other:___________ | ______________________________________________ |

## FAMILY HISTORY

64) The client lives with:

_____ Parents _____ Relatives _____ Alone _____ Family
_____ One Parent _____ Children _____ Partner
_____ Other ______________________________________________________________

65) What is the name of the client's biological mother? ______________________________________

a. Is she living? Yes _____ No _____ If deceased, explain: ___________________________
b. Her age? ______________________________________________________________
c. What is her level of education? __________________________________________________
d. Her occupation? ______________________________________________________________
e. How often did/does she see the client? _____________________________________________
f. How involved was/is the mother in the client's upbringing? Very ___Somewhat ____Not at all_____
g. Did the mother have a learning disability or other problems when she was in school? Yes __No __
   If yes, describe: ______________________________________________________________
h. What were/are the mother's hobbies?__________________________________________

66) What is the name of the client's biological father? ___________________________________________

a. Is he living? Yes _____ No _____ If deceased, explain:__________________________________
b. His age?_________________________________________________________________
c. What is his level of education? ________________________________________________
d. His occupation? ______________________________________________________________
e. How often did/does he see the client? ______________________________________________
f. How involved was/is the father in the client's upbringing? Very _____ Somewhat _____Not at all___
g. Did the father have a learning disability or other problems when he was in school? Yes ___ No ___
   If yes, describe:______________________________________________________________
h. What were/are the father's hobbies? ______________________________________________________

67) Please list the names, ages, highest educational level completed, and occupation of the client's brothers and sisters:

| **Name** | **Age** | **Education** | **Occupation** |
| --- | --- | --- | --- |
| ______________________________ | ______ | ____________ | ____________ |

_________________________________ ______ _____________ _____________

68) Has anyone in the client's biological family (including parents, grandparents, siblings, cousins, aunts & uncles) ever had any of the following:

| | **Which relative?** | **Describe the problem briefly** |
|---|---|---|
| _____ Brain disease | _____________ | ________________________________________ |
| _____ Developmental delay | _____________ | ________________________________________ |
| _____ Epilepsy or seizures | _____________ | ________________________________________ |
| _____ Learning disability | _____________ | ________________________________________ |
| _____ Mental retardation | _____________ | ________________________________________ |
| _____ Neurologic disease | _____________ | ________________________________________ |
| _____ Psychological problems | _____________ | ________________________________________ |
| _____ Reading/spelling difficulties | _____________ | ________________________________________ |
| _____ Speech/language problems | _____________ | ________________________________________ |

69) Which of the client's biological relatives are left-handed?
Mother _____ Father _____ Sibling(s) _____ Grandparents _____ No one _____

70) What languages are/were spoken in the home? (List in order of the most frequent first.)
(1) _________________________________ (2) ___________________________________________

71) How was/is the client disciplined? _______________________________________________
72) List the client's usual recreational activities and hobbies:_____________________________________
______________________________________________________________________________
73) Have there been any major family stresses or changes in the past year (e.g., moving with change of school, job change, divorce, significant illness, etc.)? Yes _____ No _____
If yes, please explain: _______________________________________________________________
How much stress have these changes caused the client? (circle one) None Mild Moderate Severe

## EDUCATIONAL HISTORY

75) Please summarize the client's progress (e.g., academic, social, testing) within each of these grade levels (Please provide name of institutions if possible):

Preschool______________________________________________________________________________
______________________________________________________________________________

Kindergarten___________________________________________________________________________
______________________________________________________________________________

Elementary School______________________________________________________________________
______________________________________________________________________________

Middle School (or Junior High School)_______________________________________________________
______________________________________________________________________________

High School ________________________________________________________________
____________________________________________________________________________

College_____________________________________________________________________
____________________________________________________________________________

Post Graduate________________________________________________________________
____________________________________________________________________________

Additional Educational Experiences (e.g., specialized training, residency)___________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

76) Has the client ever been in any type of special educational program, and if so, how long? (If yes, please explain.)

______ Learning disabilities class
Duration of placement______
______ Behavioral/emotional disorders class
Duration of placement______
______ Speech & language therapy
Duration of therapy______
______ Other (please specify)
Duration______

77) Has the client ever been: (If yes, please explain.)

______ Suspended from school
Number of suspensions______
______ Expelled from school
______Number of expulsions
______ Retained in grade
Number of retentions______

78) Have any additional instructional modifications been attempted? (If yes, please explain.)

______ None
______ Behavior modification program
______ Daily/weekly evaluation
______ Occupational Therapy
______ Tutoring/Supervision
______ Other (please explain): ______________________________________________

79) Did the client like school? Most of the time ______ Sometimes ______ Almost never

80) Did the client:

| | | |
|---|---|---|
| Have problems with other students in class? | Yes _____ | No _____ |
| Have problems making friends in school? | Yes _____ | No _____ |
| Have problems getting along with teachers? | Yes _____ | No _____ |
| Tend to get sick in the morning before school? | Yes _____ | No _____ |

81) Describe any teacher concerns (past or present) about the client's schoolwork or behavior:_________
____________________________________________________________________________
____________________________________________________________________________

82) What kind of grades did/does the client received in school?

A's & B's ______ B's & C's ______ C's & D's ______ D's & F's ______

*or*

Outstanding ____ Good ____ Satisfactory ____ Improvement needed ____ Unsatisfactory ____

*or*

Other grading system: ______________________________________________

83) Have/Did these grades change over her/his school years? Yes _____ No ____

84) How much school has/did the client miss due to illness or injury?

Less than 2 weeks ____ 2 to 4 weeks ____ 5 to 8 weeks _____ Over 8 weeks _____

Briefly describe the reasons if the client missed a lot of school: ____________________________

______________________________________________

85) Does/Did the client seem to have a "school phobia"? Yes _____ No _____

If yes, explain: ______________________________________________

______________________________________________

## EMPLOYMENT HISTORY

As best as you are able please provide a chronological list of employment. Please start with most recent employment:

Dates of Employment: ____________________ Employer: ____________________

Position: ____________________ Responsibilities: ____________________

Dates of Employment: ____________________ Employer: ____________________

Position: ____________________ Responsibilities: ____________________

Dates of Employment: ____________________ Employer: ____________________

Position: ____________________ Responsibilities: ____________________

Dates of Employment: ____________________ Employer: ____________________

Position: ____________________ Responsibilities: ____________________

Dates of Employment: ____________________ Employer: ____________________

Position: ____________________ Responsibilities: ____________________

What do you like about your current employment?____________________________

______________________________________________

What do you dislike about your current employment?____________________________

______________________________________________

## SOCIAL HISTORY

86) How does the client get along with his/her brothers/sisters?

_____ Does not have any

_____ Worse than average
_____ Average
_____ Better than average

87) How easily does the client make friends?

_____ Do not know
_____ Worse than average
_____ Average
_____ Easier than average

88) On the average, how long does client keep friendships?

_____ Less than 6 months
_____ 6 months to 1 year
_____ More than 1 year
_____ Don't know

## PREVIOUS EVALUATIONS

89) Which of these tests or procedures recently have been done? Note any abnormal findings.

| Evaluation | Check here if normal | Abnormal findings |
|---|---|---|
| _____ Blood work | _____________ | _________________ |
| _____ Family physician or pediatrician office visit | _____________ | _________________ |
| _____ Lead level check | _____________ | _________________ |
| _____ Lumbar puncture or spinal tap | _____________ | _________________ |
| _____ Neurological examination or testing (CT scan, EEG) | _____________ | _________________ |
| _____ Psychological or neuropsychological testing | _____________ | _________________ |
| _____ School testing | _____________ | _________________ |
| _____ Speech & language testing | _____________ | _________________ |
| _____ Vision testing | _____________ | _________________ |
| _____ X-rays | _____________ | _________________ |

_____ Other tests: ____________________________________________________________

THANK YOU FOR TAKING THE TIME TO CAREFULLY COMPLETE THIS QUESTIONNAIRE.
Please return this document to Lauri L. Korinek Ph.D., LLC, at:

**9364 Teddy Lane, Suite 204**
**Lone Tree, Colorado 80124**
**(303) 324-0451 Phone**
**1-800-863-6549 Fax**

______________________________________ ___________________________

Client's or Guardian's Signature Date