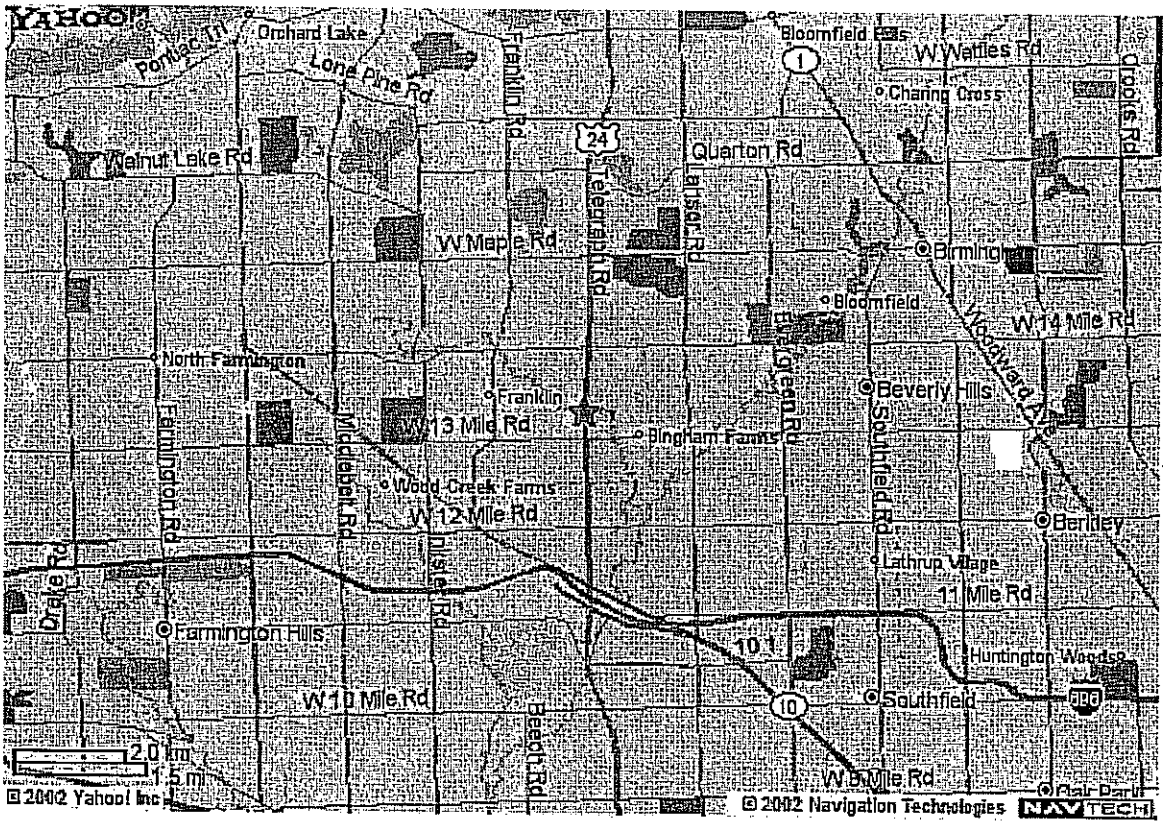
Directions

- We are located at 31600 Telegraph Road, Suite 230, on the East side of Telegraph between 13 Mile Road and 14 Mile Road.

- You will not see our building from Telegraph Road. Look for a black sign with GOLD lettering that says 31600 and leads to a large brick building with a bell tower. Go past that building; we are located behind it on the right.



Neurobehavioral Consultants, P.C.

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Name: _____ Date of Birth: _____ Parents: _____

Pediatrician/Family Physician: _____ Current Medication(s): _____

PROBLEMS (Observed/Reported)

Please indicate any problems that your child is **currently having** or has had within the **past six months** only.

LIST 1

Annoying Behavior (seems intentional)	
Argumentative	
Avoidance (e.g. people, places, activities)	
Binge Eating	
Blames Others	
Controlling	
Deceitful	
Defiance	
Difficulty Concentrating	
Difficulty Organizing	
Diminished Appetite	
Disturbed Body Perception	
Easily Distracted	
Energy Changes	
Excessive or Intense Fears	
Fasting	
Fatigue	
Feelings of Guilt or Worthlessness	
Flight of Ideas	
Hyperactive	
Hyper-Vigilance	
Immature For Age	
Inattentive	
Insomnia	
Interrupts	
Irritability	
Labile	
Lack of Empathy	
Little or No Motivation	
Loss of Temper	
Low Self-Esteem	
Memory Loss	
Motor Restlessness	
Oppositional	
Perfectionism	
Poor Social Skills	
Restricted Emotional Expression	
Sadness	
Social/Occupational Dysfunction	
Suspiciousness	
Talks Excessively	
Tics	
Unable to Follow Directions	
Use of Laxatives, Diuretics, Appetite Suppressants	
Worry	

LIST 2

Accident Prone	
Aggression	
Anxiety	
Body Weight Less Than 85% of Normal	
Depression	
Destruction of Property	
Detachment	
Disorganized Speech	
Excessive Interest (In One Thing or Idea, e.g. dinosaurs, trucks, Middles Ages)	
Impaired Communication (e.g. Delay/Lack of Spoken Language, Repetitive/Idiosyncratic Language)	
Impaired Social Interaction (e.g. No Eye Contact, Blank Facial Expression)	
Impulsivity	
Inflated Self Esteem or Grandiosity	
Irrational Fears (Death, Loss of Control)	
Low Frustration Tolerance	
Mania	
Perceptual or Cognitive Distortion	
Promiscuity	
Purging, Self-Induced Vomiting	
Repetitive Behavior (Hand Washing, Counting)	
Repetitive/Stereotypical Behaviors	
Restrictive Eating	
Serious Violation of Rules (Truancy, Run Away)	
Significant Weight Change	
Sleep Difficulties (Explain)	
Somatic Complaints	
Theft	

LIST 3

Delusions	
Disorganized Behavior	
Dissociation	
Flashbacks	
Hallucinations	
Mood Swings	
Recurrent, Persistent Intrusive Thoughts	
Repeats Words or Stock Phrases	
Self-Harm (Cutting)	
Thoughts of Death	
Use of Weapons (Excessively)	
Violence	
Other:	

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Child's History

Please fill out this questionnaire as fully as possible. If you have any questions, you can discuss them with the examiner when the history form is reviewed with you.

Child's Information

Name:_____ Birth Date:_____ Age:_____

Address:_____ Phone:_____

City:_____ Zip Code:_____

Parent/Guardian Name:_____

Parent/Guardian Address:_____

Parent/Guardian Phone:_____

What are the problems that cause you to seek help for this child? (Be specific)

_____

_____

Referring Doctor:_____ Phone:_____

Adults in the home:_____

Relationship to child:_____

Is this child adopted:_____ If so, age at adoption:_____

Status of parent's marriage:_____

	Birth Mother	Birth Father
Age:		
Highest Grade Completed:		
Diploma/Degree:		
Occupation:		
Learning Difficulty:		
Behavioral Problems:		
Emotional Problems:		

Siblings (including step-siblings and half siblings):

Name	Age	Sex	In the home?

Birth and Developmental History

PREGNANCY

Prenatal Care _____Yes _____No

Please describe any complications that occurred during the pregnancy:_____

_____

_____

Substances used **during** the pregnancy?

_____ Cigarettes How many? _____Per day:_____ Per Week:_____
_____ Alcohol How much?_____ Per day:_____ Per Week:_____
_____ Drugs Type and frequency:_____
_____ Medications Type and frequency:_____

LABOR AND DELIVERY

Mother's age at time of birth:_____ Father's age at time of birth:_____

Was the birth premature?_____ If so, how early:_____

Birth weight:_____ Length:_____ APGAR scores:_____

Was this a feet first (breech) delivery?_____ Did you have a Cesarean delivery?_____

Please describe any complications with the delivery:_____

_____

Please describe any health problems the baby had:_____

_____

How long did the child stay in the hospital?_____

Was oxygen used for the baby? ____Yes ____No

Ages at Milestones

Crawled:_____ Walked:_____ Ran Well:_____

Fed Self With Spoon:_____ Scribbled:_____Tied Shoes:_____Ride Two Wheeler:_____

Used Single Words:_____ Used Sentences (2+words):_____ Described Activity:_____

Potty Trained/Day:_____ Potty Trained/Night:_____

Rate of Development Overall: _____ Slow _____ Normal _____ Fast

Medical History

Please describe any serious injuries, illnesses, and/or surgeries your child has had._____

_____

_____

Has the child had a head injury?_____ If so, did he/she lose consciousness?_____

If he/she lost consciousness, for how long?_____ Was he/she comatose?_____

Please describe any other handicapping conditions or special health considerations and their treatments:_____

_____

Date and results of last hearing test:_____

Date and results of last vision test:_____

Please list medications (with dosage and times) currently being taken by the child, including non-prescription medications:_____

_____

_____

BEHAVIORAL AND MENTAL HEALTH HISTORY

Please describe any professional mental health treatment, such as individual, family, or group counseling, that your child has received. Please list name of the counselor, type of treatment, and length of treatment._____

_____

_____

Please list any unusual, traumatic, or possibly stressful events in the child's life that you think may have had an impact on his or her development and current functioning. Include incident, child's age at the time, and comments. Feel free to use the back of this page if more room is needed._____

_____

_____

EDUCATIONAL HISTORY

Please list the name, location, type of program, number of days per week, age when started, and how your child progressed in preschool and/or daycare programs:_____

_____

_____

Current grade and school:_____

Previous schools attended and grades at each:_____

_____

Briefly describe the child's performance academically and socially in each grade:

Kindergarten:_____

1st Grade:_____

2nd Grade:_____

3rd Grade:_____

4th Grade:_____

5th Grade:_____

Middle School:_____

High School:_____

_____

_____

Has the child been placed in special education programs currently or in the past?_____

_____ Learning Disability (LD): Subjects:_____

_____ Language Disorder: Type:_____

_____ Tutoring: Subjects:_____

Previous Psychosocial Testing:_____

FAMILY HISTORY

For the following questions, please consider the child's parents, siblings, grandparents, uncles, aunts, and cousins).

Please indicate which family members experience the following problems: inattentiveness or hyperactivity; epilepsy; migraines; alcoholism or substance abuse; anxiety, depression, learning problems, developmental disabilities, neurological disorders, or other psychological, emotional and/or personality difficulties:

Mother's side: _____

_____

Father's side: _____

_____

Please add any additional comments you think might be helpful: _____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Person Completing Form Date