

Cape Cod Neuropsychology, LLC

Mary Acunzo, Ph.D

68 Tupper Road #8 Sandwich, MA 02563

(508) 888-6869 (508) 888-5994 (fax)

info@capecodneuropsychology.com

CHILDHOOD HISTORY FORM

Child's Name: _____

Birth Date: _____ Age: _____

Parents' Names: _____

Home Phone : _____ Cellphone : _____

Email address: _____

Home Address: _____

Child's School: _____ Grade: _____

Child lives with: _____

Nonresidential adults involved with child on regular basis: _____

Source of Referral: _____

Briefly state main referral questions: _____

Parents Info

Mother: _____

Occupation: _____

Age: _____ Age at time of pregnancy: _____

School: Highest Grade: _____

Learning, attention or behavior problems (please explain): _____

Medical problems: _____

Have your blood relatives experienced problems similar to those your child is experiencing?
(explain): _____

Father: _____

Occupation: _____

Age: _____ Age at time of pregnancy: _____

School: Highest Grade: _____

Learning, attention or behavior problems (please explain): _____

Medical problems: _____

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Have your blood relatives experienced problems similar to those your child is experiencing?
(explain): _____

Child's Sibling(s) (list names, ages, and medical, social, school problems):

Perinatal/Postnatal Information:

Any complications in pregnancy? (explain): _____

Smoking during pregnancy: _____

Alcohol consumption: _____

Medications or procedures: _____

Duration of pregnancy: _____

Duration of labor: _____

Type of delivery: _____

Complications (injury, cord around neck, anoxia, hemorrhage, etc.): _____

Infant weight: _____

Post Delivery (jaundice, cyanosis, incubator care, infection, etc.): _____

Number of days in hospital after delivery: _____

Check any that applied during infancy:

Didn't enjoy cuddling _____	Colic _____	Restlessness _____
Lack of sleep _____	Head banging _____	Trouble nursing _____
Constantly into everything _____	Not easily calmed _____	

Developmental Milestones:

(note whether it was E=early, L=late, or O=on time):

Smiled: _____ Sat up: _____ Crawled: _____ Stood: _____

Walked: _____ Spoke first words: _____ Spoke in phrases: _____

Spoke in full sentences: _____ Bladder/Bowel trained: _____

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Rode Tricycle: _____ Rode Bicycle: _____ Buttoned Clothing: _____

Tied Shoes: _____ Named Colors: _____ Named Coins: _____

Said alphabet in order: _____ Began to Read: _____

Coordination

(note whether it's good, average, or poor):

Walking: _____ Running: _____ Throwing: _____

Catching: _____ Athletic Abilities: _____

Shoelace Tying: _____ Buttoning: _____ Writing: _____

Temperament & activity level: _____

Distractibility/attention: _____

Adaptability (dealing with transition and change): _____

Response to new things (food, people): _____

Mood: _____

Regularity of sleeping and eating: _____

Medical History

Childhood diseases: _____

Operations: _____

Hospitalizations: _____

Head Injuries: _____

Seizures: _____

Coma: _____

High Fevers: _____

Eye Problems: _____

Ear Problems: _____

Allergies/Asthma: _____

Sleep Problems (settling, staying asleep, snoring, walking/talking in sleep): _____

Appetite: _____

Current Medications & Dosages: _____

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Does your child have excessive number of accidents compared to others?: _____

Does your child seem to understand directions/situations as well as others?: _____

How would you describe your child's overall intelligence?: _____

Were you concerned about your child succeeding in kindergarten?: _____

Have you considered retention or retained your child a grade in school?: _____

Please describe your child's school experience briefly (Preschool through Twelfth): _____

Has your child been on an IEP (individualized educational plan)? If so, for what areas?: _____

How does your child do with his/her peers (please describe)?: _____

Do you feel your child has trouble interpreting social cues?: _____

Is your child impulsive (acts before thinks)?: _____

Does your child show motor restlessness (fidgets with hands, feet, or is hyperactive)?: _____

Does your child have trouble shifting from one activity to another?: _____

Does your child interrupt/intrude often?: _____

How is your child's eye contact?: _____

Does your child have trouble judging personal space?: _____

Is there a history of temper tantrums?: _____

Is your child easily frustrated?: _____

Has your child been aggressive? : _____

Does your child seem like he/she is "driven by a motor"?: _____

Would you describe him/her as a "different child"?: _____

How is your child's memory?: _____

How well does your child work for short term or long term reward?: _____

What type of discipline do you use at home?: _____

Have you ever had formal help/training in parenting?: _____

What are your child's interests?: _____

What are your child's accomplishments?: _____

What does your child dislike doing the most?: _____

What does your child enjoy doing the most?: _____

What do you like about your child?: _____

Please list those professional involved with your child (with phone numbers, if you can):
