New Peaks
NEUROPSYCHOLOGY

777 29th Street, Suite 200, Boulder, CO 80303
Office: 303-200-4780 • Fax: 720-647-3011

Kristin B. Powell, Ph.D., ABPP-CN
Jill Gitten Aloia, Ph.D., ABPP-CN
Zachary W. Sussman, Ph.D.
Emily C. Maxwell, Ph.D.

CHILD AND ADOLESCENT BACKGROUND HISTORY FORM

This questionnaire deals with the following: prenatal development, medical history, performance in school, and family history. Please provide as much detail as possible. If you have additional information, such as school reports or previous assessments, please bring these along. All this information will be reviewed with you in detail, but it is helpful to have a complete and accurate record before we meet. Thank you!

Name of Individual Completing Form:_____ Today's Date: _____

Child's Demographic Information:

Child's Name:	
Sex Assigned at Birth:	
Preferred Pronouns:	
Age:	
Birthdate:	
School:	
Grade:	

Please check-mark to indicate role:

	Biological	Step	Adoptive
Parent Name:	☐	☐	☐
Parent Name:	☐	☐	☐
Other Parent/Caregiver Name(s):	☐ ☐	☐ ☐	☐ ☐

If parents are separated or divorced, please specify date, age of child at that time, and explain the resulting custody arrangements:

EVALUATION OBJECTIVES: CURRENT NEEDS

What are your goals & expectations for this evaluation? What do you want to discover?

1)

2)

3)

What are your child's strengths?

1)

2)

3)

Please list your child's current difficulties. Include when you first became concerned and what you think may be the cause of the problem.

1)

2)

3)

FAMILY HISTORY

There are two Home sections below. If your child resides in one home, please complete only Home 1. If your child rotates between homes, such as in a shared-custody situation, please complete both Home 1 and Home 2. Please specify in "Relationship to Child" if it is a blood relationship.

Please list all the people living in your child's **Home 1**:

Name	Age	Relationship to Child

Please list all the people living in your child's **Home 2**:

Name	Age	Relationship to Child

Please provide information about the primary caregivers.

	Age	Level of Education	Occupation	Please describe any learning or attention difficulties
Parent 1				
Parent 2				
Other Parent/Caregiver				
Other Parent/Caregiver				

Please check for each sibling: Full or half-sibling, or biologically unrelated.

Sibling Name	Age	Level of Education	Full	Half	Not Related	Please describe any learning or attention difficulties
			☐	☐	☐	
			☐	☐	☐	
			☐	☐	☐	
			☐	☐	☐	
			☐	☐	☐	
			☐	☐	☐	

Please list and describe any medical conditions that run in the family (including but not limited to thyroid disease, diabetes, elevated blood pressure, heart problems, and cancer). See the following table for learning and psychological/psychiatric conditions.

Does any relative have:	**Yes**	**No**	**Relationship to Child** (Please specify if blood related)	**Description of Issue**
Learning Problems (Be specific)	☐	☐		
ADHD	☐	☐		
Tourette's Syndrome or tics	☐	☐		
Autism Spectrum Disorder or Asperger's Syndrome	☐	☐		
Anxiety or Panic	☐	☐		
Obsessions/Compulsions	☐	☐		
Depression	☐	☐		
Bipolar Disorder	☐	☐		
Suicidal or Self-Injurious Behavior	☐	☐		
Schizophrenia	☐	☐		
Impulsive, Risk-Taking Behavior	☐	☐		
History of Victimization or Trauma	☐	☐		
Drug or Alcohol Abuse (Be Specific)	☐	☐		
Psychiatric Hospitalization	☐	☐		
Other emotional difficulties	☐	☐		
Genetic Disorder	☐	☐		
Neurological Condition (e.g., seizures, stroke, brain tumor)	☐	☐		

OBSTETRICAL HISTORY: PREGNANCY & BIRTH

Please answer the following:

Was the child adopted? *If yes, at what age and from where?*	
Was it difficult to become pregnant and/or was medical intervention required? *If yes, please specify if possible.*	
Did the mother see a doctor for prenatal care? *If yes, please indicate month care began.*	
How many times was the mother pregnant prior to this pregnancy?	
Did she ever have any miscarriages or abortions? *If yes, please specify if possible.*	
During the pregnancy, how much weight did the mother gain (or lose)?	
Age of mother at delivery	
Age of father at delivery	

Did any of the following occur?	**Yes**	**No**	**If yes, please explain**
Amniocentesis	☐	☐	
Bleeding or Spotting	☐	☐	
Placental Abruption	☐	☐	
Kidney Trouble	☐	☐	
High Blood Pressure	☐	☐	
Swelling of Ankles	☐	☐	
Toxemia or Preeclampsia	☐	☐	
Low Salt Diet	☐	☐	
Water Pill (Diuretics)	☐	☐	
Sugar in Urine/Gestational Diabetes	☐	☐	
Rh Factor	☐	☐	
Mother receive Rhogam	☐	☐	
Sickle Cell	☐	☐	
Premature Labor	☐	☐	
Maternal Illness (Rashes, Fevers, Infections)	☐	☐	
X-Rays	☐	☐	
Accident	☐	☐	
Hospital Stay	☐	☐	
Cigarettes/Tobacco (frequency & quantity)	☐	☐	
Alcohol (frequency & quantity)	☐	☐	
Other Maternal Drug/Substance Use	☐	☐	
Emotional/Other Stress	☐	☐	

Were any of the following medications taken during this pregnancy? If yes, circle:

☐ Birth control pills	☐ Prenatal vitamins	☐ Prenatal calcium/iron	☐ Antibiotics
☐ Medicine to keep baby (prevent labor)	☐ Sleeping pills	☐ Tranquilizers	☐ Reducing Pills
☐ Anticonvulsants (for seizures)	☐ Antidepressants	☐ Steroids (prednisone)	☐ Other:

Please answer the following:

How many hours was the mother in labor?	
Apgar Scores (at 1 and 5 minutes)	
Birth weight (pounds, ounces)	
Hospital in which baby was born	
How many days after delivery did mother and baby leave the hospital?	
Was the pregnancy full-term? *If no, please indicate week of pregnancy child was born.*	
Did the mother go into labor by herself? *If no, was labor induced?*	
Was delivery by Caesarian Section? *If yes, what was the reason for the C-section?*	
Was the child born head first? *If no, what occurred?*	

Did any of the following complications occur during delivery?	**Yes**	**No**
Forceps or Vacuum extraction used	☐	☐
Premature rupture of membranes (water broke too early)	☐	☐
Doctor had to "turn" the baby	☐	☐
Multiple births (twins, triplets, etc.)	☐	☐
Hemorrhage	☐	☐
High Blood Pressure	☐	☐
Other Complications (specify):	☐	☐

Did any of the following complications occur after delivery?	**Yes**	**No**
Put in incubator	☐	☐
Blueness	☐	☐
Respiratory Issues (difficulty breathing)	☐	☐
Jaundice (yellow skin)	☐	☐
Convulsions	☐	☐
Did not feed well	☐	☐
Mother had Postpartum Depression	☐	☐
Other difficulties (specify):	☐	☐

Did any of the following difficulties occur as a newborn?	**Yes**	**No**
Colic, excessive irritability, inconsolable crying	☐	☐
Did not sleep very much	☐	☐
Stiff, arched back	☐	☐
Too floppy	☐	☐
Sleepy, lethargic – had to wake baby to feed	☐	☐
Feeding problem	☐	☐
Breathing problem	☐	☐
Did not like to be held	☐	☐
Failure to Thrive	☐	☐
Other difficulties (specify):	☐	☐

DEVELOPMENTAL HISTORY

As best you can recall, record the age at which your child reached the following developmental milestones. If you cannot recall the age, check the appropriate box to the right.

Milestone	Age	Early	Normal	Late
Sat without support		☐	☐	☐
Crawled		☐	☐	☐
Stood without support		☐	☐	☐
Walked without assistance		☐	☐	☐
Spoke first words (other than "mama" or "dada")		☐	☐	☐
Said phrases (2-3 words)		☐	☐	☐
Said sentences		☐	☐	☐
Spoke clearly and fluently		☐	☐	☐
Potty trained through the day		☐	☐	☐
Potty trained through the night		☐	☐	☐
Rode a tricycle		☐	☐	☐
Rode a bicycle		☐	☐	☐
Got dressed alone		☐	☐	☐
Buttoned own clothing		☐	☐	☐
Tied shoelaces		☐	☐	☐
Named colors		☐	☐	☐
Named letters and/or numbers		☐	☐	☐

Please answer the following:

Which hand does your child prefer to use?	
What was the approximate age at which you noticed this preference?	

Currently, how well does your child function in the following areas when compared to peers?

Skill	Much worse	Worse	Similar	Better	Far better
Walking	☐	☐	☐	☐	☐
Running	☐	☐	☐	☐	☐
Athletics	☐	☐	☐	☐	☐
Handwriting	☐	☐	☐	☐	☐
Language/Communication	☐	☐	☐	☐	☐
Following directions	☐	☐	☐	☐	☐

Please answer the following:	Yes	No	Explanation *Provider and reason for services*	Dates
Was your child evaluated through Early Childhood Intervention or Child Find?	☐	☐		
Has your child ever worked with a speech/language therapist?	☐	☐		
Has your child ever worked with an occupational therapist?	☐	☐		
Has your child ever worked with a physical therapist?	☐	☐		

SENSORY HISTORY

Has your child ever displayed the following behaviors?	Yes	No	Sometimes (If so, when?)
Avoids certain textures (sand, mud, foods, lotions, etc.)	☐	☐	
Strongly dislikes having hair washed, combed, or brushed	☐	☐	
Strongly dislikes having dirty hands	☐	☐	
Trouble tolerating touching, hugging, or cuddling	☐	☐	
Prefers to wear only certain types of clothes	☐	☐	
Frequently walks on tiptoes	☐	☐	
Overly sensitive to sounds (put hands over ears)	☐	☐	
Becomes easily distracted by environmental sounds	☐	☐	
Frequently chews on clothes or objects	☐	☐	
Avoids eating certain types of textures or foods	☐	☐	
Overly sensitive to smells	☐	☐	
Avoids swinging, sliding, or using playground equipment	☐	☐	
Seeks out swinging	☐	☐	

Has your child ever had any of the following problems?	Yes	No	Sometimes (If so, when?)
Poor balance	☐	☐	
Poor motor coordination	☐	☐	
Uses too much or too little pressure with objects	☐	☐	
Avoids using vision to coordinate hand/body movements	☐	☐	
Difficulty with puzzles, colors, and shapes	☐	☐	
Blinks excessively when trying to catch balls or balloons	☐	☐	

Has your child ever exhibited any of the following behaviors?	Yes	No
Head-banging	☐	☐
Hair-twirling	☐	☐
Hair plucking, pulling, or skin-picking	☐	☐
Hand-flapping	☐	☐
Twirling	☐	☐
Twitches or excessive eye blinks	☐	☐
Throat clearing	☐	☐
Excessive worries or fears	☐	☐
Worries about dirt or germs	☐	☐
Needs to carry out certain rituals	☐	☐
Feels they have to be perfect	☐	☐
Likes things to be very neat and clean	☐	☐
Argues a lot	☐	☐
Does not carry out requests	☐	☐
Sad, unhappy, depressed	☐	☐
Irritable	☐	☐
Hits other people	☐	☐
Frequent temper tantrums	☐	☐

Any other sensory, motor or movement concerns that have not been listed? If yes, please describe them:

_____

_____

SOCIAL HISTORY

Please answer the following:	Yes	No	If yes, please describe:
Did you have concerns about your child's attachment to caregivers (e.g., parents, daycare providers, etc.) during toddlerhood?	☐	☐	
Does your child have difficulty interpreting or using eye contact, facial expressions, or gestures?	☐	☐	
Does your child have trouble participating in back-and-forth conversation?	☐	☐	
Does your child exhibit a limited or restricted range of interests (ex: only enjoying one movie, toy, etc.)?	☐	☐	
Does your child's intensity or focus on interests exceed most of their peers (e.g., most conversations center around a specific interest)?	☐	☐	
Does your child have trouble with changes in activities or routines?	☐	☐	
Has your child ever acted aggressively upon an animal or another person?	☐	☐	
Has your child ever shown an unusual and/ or frequent interest in fire?	☐	☐	
Has your child shown limited interest in socialization (playing with others, enjoying cooperative games, etc.)?	☐	☐	
Has your child had difficulty developing and/or maintainingfriendships?	☐	☐	
Does your child have difficulty with other non-classmate children (neighbors, same-aged peers, etc.)?	☐	☐	

Please answer the following questions about your child's play activities.

Play Activity	Age	Does Well	Has Trouble	Please Explain
Plays alone		☐	☐	
Plays with other children		☐	☐	
Plays with dolls		☐	☐	
Plays with siblings		☐	☐	
Plays with imaginary friends		☐	☐	
Plays group games		☐	☐	
Participates in sports activities		☐	☐	

Please answer the following:

What activities does your child do with parents?	
What activities does your child do with siblings?	
How many close friends does your child have?	

Please answer the following:

How many children does your children prefer to interact with?	☐ 1-2 other children	☐ a small group	☐ a large group
How often does your child play with other children (non-siblings)?	☐ Less than once/week	☐ 1-3 days/week	☐ Almost everyday
Are the majority of your child's playmates	☐ Older	☐ Younger	☐ Same age as child

How does your child get along with siblings/family members?

What things does your child enjoy doing (e.g., interests, preferred activities)?

What things does your child do well?

Please describe your child's TV-watching habits.

TV Program	Is the show watched daily?	When (what time?)

Please describe the sport(s) your child enjoys and their performance.

Sport	Don't know	Below Average	Average	Above Average
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

Are there any aspects of the sport(s) your child plays that appear to be particularly challenging to your child? If yes, please explain:

What chores does your child have around the house (cleaning own room, doing dishes, taking out trash, caring for pets, etc.)? Please rate how well these activities are performed:

	Performance Rating			Frequency		
List Chore(s)	Good	Fair	Non-compliant	Needs constant reminders	Sometimes does them	Almost always does them
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐

How is your child around the house?

What are some of the discipline strategies practiced in your home?

ACADEMIC/SCHOOL HISTORY

Please list all the schools your child has attended (including nursery/preschool, kindergarten, and all grade levels). Please also indicate if school is an alternative education facility.

School Name	**Grades/Dates Attended**	**Classroom Type** (e.g., special education, regular classroom, gifted)	**Supports provided** (e.g., classroom aide, speech therapy)

Please list your child's current academic classes and grades:

Class Name	**Grade (e.g., A, B, C, D, F; S/U; I)**

Please answer the following:	**Yes**	**No**	**Explanation**
Has your child ever repeated or skipped/been accelerated through a grade? *If yes, which grade(s) and what was the reason?*	☐	☐	
Has your child previously or currently been enrolled in a special class/school, or Special Education program? *If yes, please explain program and reason. In which grade(s)?*	☐	☐	
Has your child previously or currently been provided with an Individualized Education Program (IEP)? *If yes, please provide categorization, grade when established, and grade when it ended (if applicable).*	☐	☐	
Previously or currently been provided with a Section 504 Plan? *If yes, please provide categorization, grade when established, and grade when it ended (if applicable).*	☐	☐	
Previously or currently been enrolled in an advanced or gifted curriculum? *If yes, please list subjects.*	☐	☐	

Please answer the following:

What is your child's best and/or favorite subject in school?	
What is hardest for your child in school?	
How does your child get along with other children at school?	
How does your child get along with teacher(s)?	
How many hours per night does your child spend on homework?	

Please answer the following:	**Yes**	**No**	**Explanation**
Does your child have any behavior problems in school? *If yes, please explain.*	☐	☐	
Do you feel the school is dealing with your child's problems and/or helping your child use strengths appropriately? *If no, please explain.*	☐	☐	
Do you maintain contact with the school? *If no, please explain.*	☐	☐	
Is getting homework done a source of stress in your home? *If so, please describe.*	☐	☐	

Please answer the following:	**Yes**	**No**	**Explanation**
Does your child seem more active, restless, or fidgety than other children? *If yes, when did you first notice this?*	☐	☐	
Does your child seem more impulsive, fearless, or prone to risk-taking compared to peers? *If yes, when did you first notice this?*	☐	☐	
Does your child seem easily distracted and have trouble attending to chores and/or schoolwork? *If yes, when did you first notice this?*	☐	☐	

Please describe your child's ability to handle homework (If your child does not have homework, please draw a line through this section and move on to the next section.)

Homework Task	**Don't Know**	**Needs Constant Supervision**	**Partially Independent**	**Almost Independent**	**Completely Independent**
Keeps track of own assignments.	☐	☐	☐	☐	☐
Completes daily homework assignments on time.	☐	☐	☐	☐	☐
Turns daily homework assignments in on time.	☐	☐	☐	☐	☐
Plans/completes long projects (e.g., book report) on time.	☐	☐	☐	☐	☐

Please comment on any of the above statements/questions or any other concerns you have regarding school:

_____

_____

_____

PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY

Has your child ever seen:	Yes	No	Name(s)	Dates
A psychiatrist (MD)?	☐	☐		
A psychologist (PhD or PsyD)?	☐	☐		
A therapist (LPC, MSW, LMFT, etc.)?	☐	☐		
A tutor or other academic support/coach?	☐	☐		
A neurologist (MD)?	☐	☐		

Please describe your child's typical mood:

_____

_____

_____

Please answer the following:	Yes	No	Description
Has your child previously or currently exhibited low mood for extended periods of time (several days or weeks)? *If yes, please describe.*	☐	☐	
Has your child previously or currently expressed hopelessness or thoughts of harming themself or another? *If yes, please describe.*	☐	☐	
Has your child ever exhibited frequent worries or other signs of anxiety?	☐	☐	
Has your child ever been hospitalized for psychiatric reasons? *If yes, please describe the circumstances and give the dates of hospitalization.*	☐	☐	
Are you concerned that your child might be using alcohol or drugs? *If yes, please explain your concerns.*	☐	☐	
Are you concerned that your child might have been abused or traumatized? *If, yes, please explain your concerns.*	☐	☐	
Has your child had educational, psychological or neuropsychological testing? *If yes, please list the evaluator, the date(s) testing was done & the tests taken.*	☐	☐	
Other prior evaluations? *If yes, please list evaluation type, name of evaluator, & testing date(s).*	☐	☐	

MEDICAL HISTORY

Please indicate if your child has had any of the following.

Medical Problems	Yes	No	If yes, please describe.
Vision Problems	☐	☐	
Hearing Problems	☐	☐	
Ear Infections	☐	☐	
Allergies	☐	☐	
Headaches	☐	☐	
Stomach Aches	☐	☐	
Strep Throat	☐	☐	
Heart, lung, kidney or other organ problems	☐	☐	
Diabetes	☐	☐	
Endocrine (e.g., thyroid, growth problem, etc.)	☐	☐	
Concussion	☐	☐	
Moderate or Severe brain injury	☐	☐	
Seizure	☐	☐	
Any other serious medical illness	☐	☐	
Any sporting or motor vehicle accidents	☐	☐	

Please describe your child's nighttime habits.	Yes	No
Does not like to go to bed	☐	☐
Can't fall asleep	☐	☐
Wakes up in the middle of the night	☐	☐
Wanders around in the middle of the night	☐	☐
Afraid of the dark	☐	☐
Nightmares	☐	☐
Wakes up too early in the morning	☐	☐
Very hard to wake up	☐	☐
Snores	☐	☐
Has pauses or interruptions in breathing while sleeping	☐	☐
Bedwetting	☐	☐
Falls asleep or gets drowsy during the day	☐	☐
Sleepwalking	☐	☐
Repetitive dreams	☐	☐
Limbs jerking wakes the child up	☐	☐

Please answer the following.

Does your child have a good appetite? *If no, please explain.*	
Does your child require a special diet? *If yes, please explain.*	
Does your child get enough exercise? *Please describe the kind and amount.*	
How many of hours of sleep does your child get on weeknights?	
How many of hours of sleep does your child get on weekends/holidays?	

Has your child ever had any hospitalizations or operations? If yes, please list below.

Date	Hospital Name, City and State	Reason for Hospitalization

Please list any medications that your child is currently taking. Please include vitamins, over-the-counter, and herbal remedies:

Name of Medication	Strength	When Started	How many times per day

Please list any medications your child has taken in the *past*, except for antibiotics and decongestants:

Name of Medication	Reason Prescribed	Strength	When Started	Effect (Positive/Negative)

PROFESSIONALS CURRENTLY PROVIDING CARE

Please note: In order to assure confidentiality, contact will not be made without a completed Authorization to Release/Request Information signed by the child's parent/legal guardian (and by the child, if they are between the ages of 14 and 18).

Name	Care Provided	Phone Number	Fax Number	Email Address

Please provide any other pertinent information about your child that was not adequately addressed in this form (continue on back if needed):