Quest

BOZEMAN HEALTH
DEACONESS HOSPITAL

Patient Label
Name: _____
DOB: _____
M#:_____

CHILD REGISTRATION AND HISTORY QUESTIONNAIRE

(Child History Questionnaire – Bozeman Health Neuropsychology)a

I ACKNOWLEDGE THAT THIS FORM WILL BE INCLUDED IN THE PATIENT'S MEDICAL RECORD.
THANK YOU VERY MUCH FOR YOUR TIME AND ATTENTION IN FILLING OUT THIS FORM.

Child's Name:_____ DOB:_____

Parent or guardian [(name)_____] phone: (H) _____ (W) _____

Age _____ Sex _____ Ethnic or racial background _____

Grade and school _____

Special Placement (if any) _____

Hand child uses for writing or drawing: Right ____ Left ____ Switches between them _____

Primary language _____ Secondary language _____

Medical diagnosis (if any) (1) _____

(2) _____

(3) _____

(4) _____

Who referred the child for this testing? _____

_____

Briefly describe the problem(s)

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

(Others) _____

What specific questions would you like answered by this evaluation?

(1) _____

(2) _____

(3) _____

(4) _____

(Others) _____

SYMPTOM SURVEY

For each symptom that applies to the child, place a check in the box. Compare the child to other children of the same age. Then, check if this is a NEW symptom (within the past year OR after onset of injury/illness) or an OLD symptom (over one year OR before the injury or illness). Add any comments next to the item.

1) PROBLEM SOLVING

√	New	Old	
❑	___	___	Difficulty figuring out how to do new things
❑	___	___	Difficulty making decisions
❑	___	___	Difficulty planning ahead
❑	___	___	Difficulty solving problems a younger child can do
❑	___	___	Disorganized in his/her approach to problems
❑	___	___	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
❑	___	___	Is 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
❑	___	___	Not talking
❑	___	___	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 h/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 disability)
❑	___	___	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 disapproval or emotions
❑	___	___	Gets lost easily
❑	___	___	Other 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 attending to what others say, but can sit in front of TV for long periods
❑	___	___	Attention starts out OK but can't keep it up
❑	___	___	Other attention or concentration problems: _____

5) MEMORY

√	New	Old	
❑	___	___	Forgets where he/she leaves things
❑	___	___	Forgets things that happened recently (e.g., last meal)
❑	___	___	Forgets things that happened days/weeks ago
❑	___	___	Forgets what he/she is supposed to be doing
❑	___	___	Forgets names more than most people do
❑	___	___	Forgets school assignments
❑	___	___	Forgets instructions
❑	___	___	Other memory problems _____

6) MOTOR AND COORDINATION

√	New	Old		Check the side this occurs on: Right	Left	Both Sides
❑	___	___	Poor fine motor skills (e.g., using a pencil or crayon)	___	___	___
❑	___	___	Clumsy	___	___	___
❑	___	___	Weakness	___	___	___
❑	___	___	Tremor	___	___	___
❑	___	___	Muscles are tight or spastic	___	___	___
❑	___	___	Odd movements (posturing, odd hand movements)	___	___	___
❑	___	___	Drops things more than most children			
❑	___	___	Has an unusual walk or problems running			
❑	___	___	Balance problems			
❑	___	___	Other motor or coordination problems: _____			

7) SENSORY

√	New	Old		Check the side this occurs on: Right	Left	Both Sides
❑	___	___	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 or 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	
❑	___	___	Aggressive
❑	___	___	Attached to things, not people
❑	___	___	Bedwetting
❑	___	___	Bizarre behavior
❑	___	___	Bowel movements in underwear
❑	___	___	Dependent
❑	___	___	Depressed
❑	___	___	Eating habits are poor
❑	___	___	Emotional
❑	___	___	Fearful
❑	___	___	Immature
❑	___	___	Nervous
❑	___	___	Nightmares, night terrors, sleepwalks
❑	___	___	Quiet
❑	___	___	Resists change
❑	___	___	Risk-taking
❑	___	___	Self-mutilates
❑	___	___	Self-stimulates
❑	___	___	Shy and withdrawn
❑	___	___	Sleeping habits are poor
❑	___	___	Swears a lot
❑	___	___	Unmotivated
❑	___	___	Other unusual behavior _____

Below, check all the descriptions of the child that have been present for at least the past 6 months. These behaviors should occur more frequently than in other children of the same age.

_____ Careless
_____ Is easily distracted
_____ Has a hard time concentrating for long periods
_____ Rarely follows others' instructions
_____ Doesn't listen to other people
_____ Goes from one activity to another without finishing anything
_____ Seems like he/she frequently is losing things that are needed for school
_____ Forgetful in daily activities
_____ Seems disorganized
_____ Is very fidgety
_____ Can't remain seated
_____ Can't wait for his/her turn when playing with others
_____ Answers before he/she hears the whole question
_____ Frequently makes noise when playing
_____ Seems like he/she is always talking
_____ Is often rude or interrupts others
_____ Seems like driven by a motor
_____ Can't seem to play quietly
_____ Frequently does dangerous things without considering the consequences
_____ Loses temper easily
_____ Argues with adults
_____ Refuses to comply with requests
_____ Easily blames others for mistakes and problems
_____ Easily annoyed or irritated
_____ Seems angry and resentful
_____ Steals things without people knowing on several occasions

_____ Often runs away from his parents' home and stays away overnight
_____ Easily lies to others
_____ Fire setting
_____ Doesn't go to school
_____ Breaks into other people's property
_____ Destroys other people's property in some manner other than by fire
_____ Is cruel to animals
_____ Has forcible sexual relations with others
_____ When fighting, has used a weapon on more than one occasion
_____ Starts fights with others
_____ Will steal directly from people
_____ Is cruel to other people

10) Overall, the child'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 birth: _____ Father's age at 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 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)
_____ Diabetes
_____ High blood pressure
_____ Illnesses or infections
_____ Preeclampsia, eclampsia, or toxemia
_____ Psychological problems
_____ Surgery
_____ Vomiting (severe or frequent)

22) How many pregnancies did the mother have prior to this one?

Number of live births: _____
Number of miscarriages: _____

BIRTH HISTORY

23) Was the child born:

Early ____ How early? _____ weeks
On time ____ (38-42 weeks)
Late ____ How late? _____ weeks

24) How much did the baby weight at birth? _____ lbs. _____ oz. OR _____ gms

25) How long did the labor last? _____

26) The labor was: Easy _____ Moderately difficulty _____ 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 baby born:

Head first ____ Transverse (crosswise) ____ Posterior first ____
Breech birth ____ Caesarean section ____ Vacuum extraction ____

30) Did the baby experience any of these problems:

Fetal distress _____ Low placenta (Placenta previa) _____Prolapsed cord _____
Premature separation of the placenta (Abruptio placenta) _____

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

_____

32) At birth, did the baby:

Have difficulty breathing?	Yes ___	No ___
Fail to cry?	Yes ___	No ___
Appear Inactive?	Yes ___	No ___

33) List the baby's Apgar scores, if known: 1st ___ 2nd ___

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

_____

_____

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

_____

36) Describe any special problems that the baby had in the first few days or weeks following birth:

_____

_____

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

_____

38) How long did the baby stay in the hospital? _____

DEVELOPMENTAL HISTORY

39) For each area, indicate the child's development 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 child'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
Pedals a tricycle	Early	Average (32-26 months)	Late

LANGUAGE

Followed simple commands	Early	Average (12-18 months)	Late
Used single-word	Early	Average (12-24 months)	Late
Said phrases	Early	Average (24-36 months)	Late
Names primary colors	Early	Average (36 to 48 months)	Late

ADAPTIVE

Toilet trained	Early	Average (13-36 months)	Late
Feeds self with spoon	Early	Average (21-24 months)	Late
Takes off open shirt/coat	Early	Average (18-24 months)	Late

40) List any other significant developmental problems:

_____

_____

41) Overall, the child's development was:
Early ____ Average ____ Late ____

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

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

44) Toilet training was: Easy ____ Difficult ____

45) As an infant, to a significant degree, were any of the following present during the first two years of life?

Did not enjoy cuddling ____
Was not calmed by being held or stroked ____
Difficult to comfort or colic ____
Excessive restlessness ____
Poor sleep ____
Head banging ____
Difficult nursing ____

46) Please rate the following behaviors as you child appeared during infancy and toddlerhood:

Activity Level – How active has your child been from an early age? _____

_____

Distractibility – How well did your child pay attention? _____

_____

Adaptability – How well did your child deal with transition and change? _____

_____

Approach/Withdrawal – How well did your child respond to new things (i.e. people and places)?

_____

Mood – What was your child's basic mood? _____

_____

Regularity – How predictable was your child in patterns of sleep, appetite, routines, etc.? _____

_____

47) Did the child have a good appetite as a baby? Yes ___No ___

48) Did the child fail to gain weight steadily as a baby? Yes ___No ___

49) List the baby's illnesses or physical problems during the first year:

_____

50) Has the child 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 child ever been hit hard on the head or suffered a head injury? Yes ___No ___

If yes, what age(s)? _____ Did the child lose consciousness? Yes ___No ___

How did it happen? _____

What problems did the child have (physical or mental) afterwards?

_____

_____

52) Has the child been diagnoses with seizures or epilepsy?

If yes, which type? Partial seizure ___ Generalized seizure ___ Unclassified type ___

If medication is used, what medication(s)? _____

Has the child ever had a bad reaction to this medicine? Yes ___ No ___

If yes, describe: _____

Did the child ever have a seizure due to a fever or unknown cause? Yes ___ No ___

If yes, describe (age, nature of seizure): _____

53) Was the child ever in the hospital for an accident, injury, or operation? Yes ___ No ___

If yes, what age(s)? _____ What happened? _____

_____

_____

54) Has the child ever swallowed any poison, non-food, or drug accidentally? Yes ___ No ___

If yes, what age(s)? _____ What happened? _____

55) Did the child 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 child 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

____ Eye problems ___ Tics (eye blinking, sniffing, and repetitive movement)

____ Other problems _____

57) As the child has been growing up, he/she has been sick:
Much of the time ____ An average amount ____ Not much at all ____

58) List all the medications the child takes now:

Medication	Route (Oral, injection, etc)	Dosage	How often?	What for?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

59) Does the child?

Wear glasses? Yes ___ No ___ (Farsighted ___ Nearsighted ___ Other ___)
Use a hearing aid? Yes ___ No ___

60) Within the past year has the child had: RESULTS

A vision test? Yes ___ No ___ _____
A hearing test? Yes ___ No ___ _____

61) What is the child's: Height: _____ ft. _____ in. Weight: _____ lbs.

62) When was the child's last medical checkup? _____

63) What therapies have been provided to the child? _____ No therapies

_____ Occupational therapy
_____ Physical therapy
_____ Psychological therapy, counseling, or cognitive rehabilitation
_____ Speech therapy
_____ Other therapy _____

FAMILY HISTORY

64) The child lives with:

___ Biological parent(s) only ___ Relatives ___ Foster parents

___ Biological parent and other ___ Adoptive parents ___ Institutional care

___ Other placement _____

Please list all the people currently living in the home with the child and their relation to the child (include family and nonfamily members) _____

_____

_____

65) What is the name of the child'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? _____

If mother works outside the home, how may hours and what days _____

e. Does she live in the same house as the child? Yes ____ No ____

f. How often does she see the child? _____

g. How involved is the mother in the child's upbringing? Very ___ Somewhat ___ Not at all ___

h. During school, did the mother have:

Learning problems _____

Attention problems _____

Behavior problems _____

Medical problems _____

i. What are the mother's hobbies? _____

j. What is mother's primary language _____ Secondary language _____

66) What is the name of the child'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? _____

If father works outside the home, how may hours and what days _____

e. Does he live in the same house as the child? Yes ____ No ____

f. How often does he see the child? _____

g. How involved is the father in the child's upbringing? Very ___ Somewhat ___ Not at all ___

h. During school, did the father have:

Learning problems _____

Attention problems _____

Behavior problems _____

Medical problems _____

i. What are the father's? _____

j. What is father's primary language _____ Secondary language _____

67) Please list the names, ages, and grade (or job) of the child's brothers and sisters:

Name	Age	Grade or job	Medical, Social, School Problems
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

68) Has anyone in the child's biological family (including parents, grandparents, siblings, aunts, and 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 child's biological relatives are left-handed? No one _____

Mother ____ Father ____ Sibling(s) _____ Grandparents ____

70) What languages are spoken in the home? (List in order of most frequent first)

(1) _____ (2) _____

71) How is the child disciplined? _____

_____

Is the discipline effective? _____

72) List the child'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, divorce, significant illness, etc.)? Yes ___ No ___

If yes, explain: _____

_____

_____

How much stress have these changes caused the child? (circle one)

None Mild Moderate Severe

74) Does the child attend day care outside the home or does someone come into the home to provide the service? _____

Does day care provide any type of formal program of play, developmental, or academic activites?

_____

_____

PEER RELATIOHSIPS

75) Does your child seek friendships with peers? _____

_____

76) Is your child sought by peers for friendship?_____

_____

77) Does your child play with children primarily his or her own age ? _____

Younger? _____ Older? _____

78) Describe any problems your child may have with peers _____

_____

SCHOOL HISTORY

79) The child's present school is: Name _____

Address _____

Phone _____ Contact person _____

80) Was the child ever held back to repeat a grade? Yes ___ No ___

If yes, which grade? _____ Why? _____

_____

81) Has the child ever been in a special class or provided with special services (e.g., RSP, Self-contained day class, learning or language disability class, etc.) Yes ___ No ___

If yes, describe the special class _____

_____

Is the child in this class or receiving special services now? Yes ___No ___

If yes, describe the present class placement _____

_____

82) Does the child have an Individualized Education Plan (IEP)? Yes ___No ___
(If so, please try to provide us with the most recent IEP records from the school.)

83) Has your child been tested at school by a school psychologist (known as "psychoeducational evaluation" often including IQ and academic achievement tests, and behavior questionnaires)? Yes ___ No ___

(If so, please try to provide us with the reports from such testing, by your request to the school.)

84) Does the child like school? Most of the time ___ Sometimes ___ Almost never ___

85) Does the child:
Have problems with other children 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 ___

86) Describe the teacher's concerns about the child's schoolwork or behavior (i.e., tell us what you have heard as themes in parent-teacher conferences, or other comments by teachers):

_____

_____

_____

87) What kind of grades has the child received in the past year?

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 _____

Are these grades a change from previous years? Yes ___ No ___

If yes, describe _____

_____

88) In which subject(s) does the child do best? _____

_____

89) Which subject(s) are the most difficult? _____

_____

90) In the past year, how much school has the child missed due to illness or injury?

Less than 2 weeks ___ 2-4 weeks ___ 5-8 weeks ___ Over 8 weeks ___

Briefly describe the reasons if the child has missed a lot of school:

_____

_____

91) Does the child seem to have a "school phobia?" Yes ___ No ___

If yes, explain: _____

92) Do you consider your child to understand directions and situations as well as other children his or her age? _____

_____

93) How would you rate your child's overall intelligence compared to other children?
Below average _____ Above average _____ Average _____

PREVIOUS EVALUATIONS

94) Which of these tests or procedures has recently has been done? Note if normal or abnormal

Evaluation	Normal	Abnormal	Date
___ Blood work	_____	_____	_____
___ Family physician or pediatrician office visit	_____	_____	_____
___ Hearing testing	_____	_____	_____
___ Lumbar puncture or spinal tap	_____	_____	_____
___ Neurological examination or testing (CT scan, EEG)	_____	_____	_____
___ Psychological or Neuropsychological testing	_____	_____	_____
___ School testing	_____	_____	_____
___ Speech & Language testing	_____	_____	_____
___ Vision testing	_____	_____	_____
___ Other tests: _____	_____	_____	_____

95) What are the names of the physician, psychologist, school authority, or other professionals who are most familiar with the child's problems?

Name _____ Name _____

Address _____ Address _____

_____ _____

Phone _____ Phone _____

Profession _____ Profession _____

Please Note: If your child has seen a psychologist at any time in the last year for testing or treatment, please be sure to advise the neuropsychologist.

ADDITIONAL COMMENTS: Please note below any further information you feel may be helpful in the evaluation of your child

_____

_____

_____

_____

_____

A parenting plan is in place and I will provide a copy before the appointment.

I ACKNOWLEDGE THAT THIS FORM WILL BE INCLUDED IN THE PATIENT'S MEDICAL RECORD. THANK YOU FOR TAKING THE TIME TO CAREFULLY COMPLETE THIS QUESTIONNAIRE

Print Name of Patient/Patient Representative: _____ DOB: _____

Signature of Patient/ Patient Representative: _____ Date: _____