Main Line Neuropsychology, PLLC
Jennifer Badgley, PhD
Office Location: 30 S. Valley Road, Suite 207, Paoli, PA 19301
Mailing Address: 43 Paoli Plaza #1448, Paoli, PA 19301
Phone: 610.500.4700 Fax: 484.585.1673

Child History Form

Please provide information to the best of your knowledge. If some questions are not applicable to you or your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet. All information is confidential. Although lengthy, the information that you provide on this form will help me gain a better understanding of your child and help me best assist you. Thank you for taking the time to complete it.

GENERAL INFORMATION:

Child's name: _____ Today's Date: _____
First Middle Last

Gender of child: ☐ Male ☐ Female Birth date of child: _____ Age: _____

Child lives at: _____
Number and Street City, State, Zip

Home Phone: _____ Alternate Phone: _____

Email Address:_____

Form completed by: _____ Relationship to child: _____

REFERRAL INFORMATION:

Current Pediatrician or Family Doctor:

Name: _____

Telephone: _____ Fax: _____

☐ **If you **DO NOT** want me to send a copy of the report to this physician, please mark here.

Who referred you to (how did you hear about) Main Line Neuropsychology, PLLC? _____

CURRENT CONCERNS:

What are your current concerns and how long have they been a concern?

_____

_____

_____

What type of services are you seeking?

_____

_____

Main Line Neuropsychology, PLLC
Jennifer Badgley, PhD
Office Location: 30 S. Valley Road, Suite 207, Paoli, PA 19301
Mailing Address: 43 Paoli Plaza #1448, Paoli, PA 19301
Phone: 610.500.4700 Fax: 484.585.1673

PRENATAL AND POSTNATAL HISTORY:

PRE-NATAL HISTORY:

Please answer which of the following conditions may have occurred during this pregnancy and explain (month, amount, treatment, etc.) in the space below:

Yes	No		Yes	No	
☐	☐	Edema (swelling of the hands and feet)	☐	☐	Epilepsy (Seizure)
☐	☐	Vaginal bleeding (when? _____)	☐	☐	Infections (colds, flu, urinary tract)
☐	☐	Toxemia	☐	☐	Other illnesses
☐	☐	Emotional stress	☐	☐	Cigarettes used (average #/Day)
☐	☐	High blood pressure	☐	☐	Alcohol used
☐	☐	X-ray studies	☐	☐	Marijuana used
☐	☐	Hospitalization	☐	☐	Cocaine used
☐	☐	Fever	☐	☐	Other drugs used
☐	☐	Operations (specify below)	☐	☐	Injuries
☐	☐	Medications used (specify below)	☐	☐	Diabetes
☐	☐	Preterm labor			

Please explain all "Yes" answers

_____

_____

_____

BIRTH HISTORY:

Was the baby born on time? ☐ Yes ☐ No

If No, was he/she ☐ Early or ☐ Late Length of pregnancy (weeks)? _____

Age of mother at birth: _____ Age of father at birth: _____

Weight of child at birth: _____ Type of delivery (please circle): C-Section or Vaginal

Please check the following conditions that may have occurred during delivery:

Type of Labor Onset: ☐ Induced ☐ Spontaneous

Type of Anesthesia: ☐ Gas ☐ Spinal ☐ Local

Baby's Presentation: ☐ Breech ☐ Head ☐ Transverse (sideways)

Please check the following problems that may have occurred during labor:

Yes	No		Yes	No	
☐	☐	Toxemia/eclampsia	☐	☐	Fetal distress
☐	☐	Maternal fever	☐	☐	Medications used (please specify: _____)

Main Line Neuropsychology, PLLC
Jennifer Badgley, PhD
Office Location: 30 S. Valley Road, Suite 207, Paoli, PA 19301
Mailing Address: 43 Paoli Plaza #1448, Paoli, PA 19301
Phone: 610.500.4700 Fax: 484.585.1673

CHILD'S POST DELIVERY PERIOD:

Check which of the following problems may have occurred after the child's birth and explain the amount and treatment in the space below.

Yes	No		Yes	No	
☐	☐	Trouble breathing	☐	☐	Jaundice
☐	☐	Cord around the neck	☐	☐	Poor feeding
☐	☐	Knot in cord	☐	☐	Required a blood transfusion
☐	☐	Prolapsed cord	☐	☐	Vomiting / reflux
☐	☐	Hemorrhage (bleeding) in head	☐	☐	Floppy muscle tone
☐	☐	Hydrocephalus (water on the brain)	☐	☐	Incubator care
☐	☐	Cyanosis (turned blue)	☐	☐	Infection
☐	☐	Need for ventilation	☐	☐	Fever

Please explain all "Yes" answers:

_____

_____

Number of days infant stayed in the hospital after delivery:_____

Apgar Scores (if known): 1 minute _____ 5 minutes _____ 10 minutes _____

INFANCY:

Were any of the following present in your baby to a significant degree during the first few years of life? If so, please describe:

Yes	No		Yes	No	
☐	☐	Difficulty feeding	☐	☐	Extremely passive
☐	☐	Excessive irritability	☐	☐	Frequent head banging
☐	☐	Difficulty comforting	☐	☐	Excessive restlessness
☐	☐	Difficulty sleeping	☐	☐	Always had to be held
☐	☐	Did not like to cuddle	☐	☐	Significant separation anxiety

Please explain all Yes answers:

_____

HEALTH HISTORY:

MEDICATION HISTORY:

Does your child take medication? ☐ Yes ☐ No

Medication	Dosage	Frequency	Start date – End date	Reason for discontinuing

Main Line Neuropsychology, PLLC
Jennifer Badgley, PhD
Office Location: 30 S. Valley Road, Suite 207, Paoli, PA 19301
Mailing Address: 43 Paoli Plaza #1448, Paoli, PA 19301
Phone: 610.500.4700 Fax: 484.585.1673

MEDICAL HISTORY:

Please check which of the following your child has had and note the age, any complications, and frequency below:

Yes	No		Yes	No	
☐	☐	Hospitalizations	☐	☐	Vision problems
☐	☐	Surgery	☐	☐	Hearing problems
☐	☐	Trauma (stitches / broken bones)	☐	☐	Asthma
☐	☐	Head trauma	☐	☐	Allergies
☐	☐	Loss of consciousness	☐	☐	Stomach aches
☐	☐	Coma	☐	☐	Excessive vomiting
☐	☐	Seizures	☐	☐	Pica (eating nonfood items)
☐	☐	Tics	☐	☐	Sleep problems
☐	☐	Staring spells	☐	☐	Bed wetting
☐	☐	Tremor	☐	☐	Stool soiling
☐	☐	Poor muscle tone	☐	☐	Bowel problems
☐	☐	Falls frequently	☐	☐	Ear infections (how many?)_____
☐	☐	Anemia	☐	☐	Other infections
☐	☐	Persistent high fever	☐	☐	Accidental poisoning
☐	☐	Headaches	☐	☐	Other medical problems

Please explain all Yes answers:

_____

_____

Please check Yes/No for the following tests/labs your child may have had:

Yes	No	
☐	☐	Brain Scan (CT/MRI): Date: _____ Results: _____
☐	☐	Lab Test (EEG): Date: _____ Results: _____
☐	☐	Genetic/Chromosome Test: Date: _____ Results: _____
☐	☐	Other_____: Date: _____ Results: _____

SERVICES / INTERVENTION:

Has your child previously or does he/she currently participate in any of the following?:

	Frequency: (e.g.,times/week)	Duration:	Beginning/Ending Dates:	Where:
Speech & Language Therapy				
Occupational Therapy				
Physical Therapy				
Psychotherapy				
Psychiatric Care				
Neurologic Exam				

Main Line Neuropsychology, PLLC
Jennifer Badgley, PhD
Office Location: 30 S. Valley Road, Suite 207, Paoli, PA 19301
Mailing Address: 43 Paoli Plaza #1448, Paoli, PA 19301
Phone: 610.500.4700 Fax: 484.585.1673

Other:				

DEVELOPMENTAL MILESTONES:

Please list the age at which your child accomplished the following developmental milestones. If you feel the milestone is not appropriate yet for the age of your child, please write N/A.

Milestone:	**Age Milestone Accomplished**	**Do you feel it was met On-Time, Early, or Late?**
Smiled in response (social smile)	_____	☐ On-Time ☐ Early ☐ Late
Sat independently	_____	☐ On-Time ☐ Early ☐ Late
Crawled independently	_____	☐ On-Time ☐ Early ☐ Late
Walked independently	_____	☐ On-Time ☐ Early ☐ Late
Said "mama" or "dada" specifically	_____	☐ On-Time ☐ Early ☐ Late
Said 1st word other than "mama" or "dada"	_____	☐ On-Time ☐ Early ☐ Late
Put two words together	_____	☐ On-Time ☐ Early ☐ Late
Put 4 to 5 sentences together to relate an experience	_____	☐ On-Time ☐ Early ☐ Late
You understood 100% of what your child said	_____	☐ On-Time ☐ Early ☐ Late
Knew primary colors	_____	☐ On-Time ☐ Early ☐ Late
Said the letters of the alphabet	_____	☐ On-Time ☐ Early ☐ Late
Printed first and last name	_____	☐ On-Time ☐ Early ☐ Late
Tied shoes	_____	☐ On-Time ☐ Early ☐ Late
Snapped, zipped, buttoned clothing	_____	☐ On-Time ☐ Early ☐ Late
Began to read	_____	☐ On-Time ☐ Early ☐ Late
Toilet trained (urine)	_____	☐ On-Time ☐ Early ☐ Late
Toilet trained (bowel)	_____	☐ On-Time ☐ Early ☐ Late

What language(s) is most often spoken in the home?: _____

Does your child speak and/or understand any language other than English?: _____

FAMILY HISTORY:

Marital Status of Parents:

☐ Married for _____ years ☐ Never married ☐ Separated ☐ Divorced ☐ Widowed

**** If parents are divorced, who has primary conservatorship of this child (who has the right to consent to psychological services)?**

_____

**** *Please attach a copy of the divorce decree.***

Main Line Neuropsychology, PLLC
Jennifer Badgley, PhD
Office Location: 30 S. Valley Road, Suite 207, Paoli, PA 19301
Mailing Address: 43 Paoli Plaza #1448, Paoli, PA 19301
Phone: 610.500.4700 Fax: 484.585.1673

Child currently lives with: *(Please check all that apply)*

☐ Natural Mother ☐ Natural Father ☐ Stepmother ☐ Stepfather

☐ Adoptive Mother ☐ Adoptive Father ☐ Foster Mother ☐ Foster Father

☐ Grandmother ☐ Grandfather ☐ Other (Specify) _____

If this child is adopted, please state child's adoption age and date of adoption: _____

Mother's History:

Mother's name: _____ Home phone: _____
First Middle Last

Other phone: _____ Occupation: _____

Mother's country of origin: _____

School history: Highest grade completed: _____ Learning problems? ☐ Yes ☐ No Attention problems? ☐ Yes ☐ No

Medical problems? ☐ Yes ☐ No Psychiatric problems? ☐ Yes ☐ No

If "Yes", please describe: _____

Father's History:

Father's name: _____ Home phone: _____
First Middle Last

Other phone: _____ Occupation: _____

Father's country of origin: _____

School history: Highest grade completed: _____ Learning problems? ☐ Yes ☐ No Attention problems? ☐ Yes ☐ No

Medical problems? ☐ Yes ☐ No Psychiatric problems?☐ Yes ☐ No

If "Yes", please describe:_____

_____

Names of Household Members	Age	Gender M / F	Relationship to Child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Main Line Neuropsychology, PLLC
Jennifer Badgley, PhD
Office Location: 30 S. Valley Road, Suite 207, Paoli, PA 19301
Mailing Address: 43 Paoli Plaza #1448, Paoli, PA 19301
Phone: 610.500.4700 Fax: 484.585.1673

Please list age and gender of any other siblings living outside the home:_____

Any immediate or extended family members with the following?

☐ Depression ☐ Learning Difficulties ☐ Mental Retardation

☐ Anxiety ☐ Attention-Deficit/Hyperactivity Disorder ☐ Obsessive-Compulsive Disorder

☐ Autism/Asperger's Disorder ☐ Bipolar Disorder ☐ Other:_____

Please explain relation to child (e.g., mother, father):_____

Have any of the following events occurred within the past 12 months?

☐ Parents divorced or separated ☐ Parent changed job ☐ New baby at home ☐ Child changed schools

☐ Family accident or illness ☐ Death in family ☐ Conflict in family ☐ Child repeated a grade

☐ Family financial problems ☐ Family moved ☐ Other stressor: _____

Please explain:_____

CURRENT EATING AND SLEEP HABITS:

EATING HABITS:

How would you rate your child's appetite? ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Is your child a picky eater? ☐ Yes ☐ No

SLEEP HABITS:

Where does your child sleep?

☐ Own bedroom

☐ Bedroom parent(s) sleep in

☐ Bedroom shared with 1 2 3 4 5 or more others (not parents)

specify with whom: _____

☐ Room other than a bedroom (describe:_____)

Does your child have problems falling asleep? ☐ Yes ☐ No

If Yes, how long does it take for him/her to fall asleep? _____

Does your child wake up in the middle of the night? ☐ Yes ☐ No

If Yes, how many times per night typically? _____

How long does it take for him/her to go back to sleep? _____

Does your child snore? ☐ Yes ☐ No Is your child restless during sleep? ☐ Yes ☐ No

Does your child experience: Nightmares ☐ Yes ☐ No
Night Terrors ☐ Yes ☐ No
Sleep Walking/Talking ☐ Yes ☐ No

How many hours total sleep does your child currently sleep at night?_____

Does your child nap? ☐ Yes ☐ No

Main Line Neuropsychology, PLLC
Jennifer Badgley, PhD
Office Location: 30 S. Valley Road, Suite 207, Paoli, PA 19301
Mailing Address: 43 Paoli Plaza #1448, Paoli, PA 19301
Phone: 610.500.4700 Fax: 484.585.1673

BEHAVIOR, DISCIPLINE, AND EMOTIONAL:

Please describe briefly any behavioral problems at *school*: _____

_____

Please describe briefly any behavioral problems at *home*: _____

_____

Describe your child's typical mood (e.g., happy, sad): _____

_____

Types of discipline you use with your child:

☐ Rewards ☐ Verbal reprimands / verbal demands

☐ Time out (isolation) ☐ Removal of privileges

☐ Ignoring behavior ☐ Physical punishment

☐ Giving in to child ☐ Other (please specify)_____

Which form(s) of discipline has proven most effective? _____

Does your child currently (within the past 6 months) display any of the following behaviors frequently or intensively? (please check)

☐ Fainting, falling	☐ Anxiety	☐ Low frustration tolerance	☐ Physical aggression
☐ Clumsiness	☐ Unusual fears	☐ Impulsivity	☐ Stealing
☐ Shy, timid	☐ Avoidance	☐ Hyperactivity	☐ Use of profanity
☐ Social Isolation	☐ Laziness	☐ Attention seeking	☐ Skipping school
☐ Lack of confidence	☐ Obsessive-compulsive behaviors	☐ Irritability	☐ Fire setting
☐ Low self-esteem	☐ Stereotyped/repetitive behaviors	☐ Temper tantrums	☐ Destructiveness
☐ Crying episodes	☐ Memory loss	☐ Oppositional behavior	☐ Cruelty to animals
☐ Unhappiness	☐ Poor concentration	☐ Noncompliance	☐ Gang Involvement
☐ Concern with weight	☐ Short attention span	☐ Defiance	☐ Cigarette use
☐ Sleep problems	☐ Distractibility	☐ Lying	☐ Alcohol / Substance use
☐ Other:			

Please provide additional information about any of the above you feel would be helpful: _____

_____

Main Line Neuropsychology, PLLC
Jennifer Badgley, PhD
Office Location: 30 S. Valley Road, Suite 207, Paoli, PA 19301
Mailing Address: 43 Paoli Plaza #1448, Paoli, PA 19301
Phone: 610.500.4700 Fax: 484.585.1673

Please check the following based on your child's current behaviors (*Check current concerns, but explain below if the behavior was a concern in the past.):

Is your child sensitive to any of the following?: ☐ Sound, ☐ Light, ☐ Touch, ☐ Smell

Does your child have difficulty with transitions? ☐ Yes ☐ No

Does your child cry easily? ☐ Yes ☐ No

Is your child clingy? ☐ Yes ☐ No

Does your child have frequent temper tantrums? ☐ Yes ☐ No

Is your child affectionate? ☐ Yes ☐ No

Is your child aggressive? ☐ Yes ☐ No

Does your child talk obsessively about certain topics? ☐ Yes ☐ No; Which topic? _____

Do you feel your child speaks too loudly? ☐ Yes ☐ No

Does your child exhibit an odd prosody (i.e., rhythm, intonation) to his/her speech? ☐ Yes ☐ No

Does your child speak in overly formal (pedantic) language for his/her age? ☐ Yes ☐ No

Does your child exhibit good eye contact? ☐ Yes ☐ No

Does your child exhibit any restricted interests that appear abnormal in intensity? ☐ Yes ☐ No; What type?_____

Does your child exhibit any repetitive motor mannerisms (e.g., hand or finger flapping)? ☐ Yes ☐ No; What type?_____

Does your child exhibit any tic-like behavior? ☐ Yes ☐ No

Does your child prefer to play by himself/herself instead of with others? ☐ Yes ☐ No

Does your child exhibit a persistent preoccupation with parts of objects? ☐ Yes ☐ No

Does your child exhibit inflexible adherence to nonfunctional routines or rituals? ☐ Yes ☐ No

Does/Did your child engage in pretend play? ☐ Yes ☐ No

Does/Did your child show/point/bring objects to you? ☐ Yes ☐ No

Please provide additional information about any of the above that you feel would be helpful:_____

PERSONAL/SOCIAL:

What are your child's main hobbies and interests? _____

Main Line Neuropsychology, PLLC
Jennifer Badgley, PhD
Office Location: 30 S. Valley Road, Suite 207, Paoli, PA 19301
Mailing Address: 43 Paoli Plaza #1448, Paoli, PA 19301
Phone: 610.500.4700 Fax: 484.585.1673

What about your child are you most proud of? _____

_____

What does your child enjoy doing most? _____

_____

What does your child dislike doing most? _____

_____

How many close friends does your child have? _____

Does your child have a best friend? ☐ Yes ☐ No If Yes, how old is he or she? _____

How easily does your child make friends? ☐ Worse than average ☐ Average ☐ Better than average

How well does your child get along with friends? ☐ Worse than average ☐ Average ☐ Better than average

If worse than average, please explain:_____

_____

Does your child get along best with: ☐ Older children ☐ Children of the same age ☐ Younger children

EDUCATIONAL HISTORY:

Has your child received Early Intervention Services? ☐ Yes ☐ No

Has your child received Head Start Services? ☐ Yes ☐ No

Has your child received Preschool Special Education Services? ☐ Yes ☐ No

Has your child had an Individual Education Program (IEP)? ☐ Yes ☐ No

Has your child received 504 Accommodations? ☐ Yes ☐ No

Did your child attend preschool? ☐ Yes ☐ No If yes, at what age? _____

Name of preschool: _____

Were there any adjustment problems in preschool? ☐ Yes ☐ No

Were you concerned about your child's ability to succeed in preschool? ☐ Yes ☐ No

Name of child's current school: _____

School district: _____

Address of school: _____

Telephone: _____ Grade: _____ Teacher: _____

Current class placement: ☐ Regular Ed ☐Special Ed ☐ Advanced/Gifted
☐ Bilingual ☐ English as a Second Language (ESL) ☐ Deaf-Ed Classroom

Main Line Neuropsychology, PLLC
Jennifer Badgley, PhD
Office Location: 30 S. Valley Road, Suite 207, Paoli, PA 19301
Mailing Address: 43 Paoli Plaza #1448, Paoli, PA 19301
Phone: 610.500.4700 Fax: 484.585.1673

Has cognitive or academic/achievement testing been completed by the school or by a private provider (e.g., neuropsychologist, psychologist)? ☐ Yes ☐ No Date:_____

***** If yes, please attach a copy of the evaluation.***

Is your child ☐ Often ☐ Seldom ☐ Never absent from school?

Usual reason for absence_____

Has your child ever been retained? ☐ Yes ☐ No What grade? _____ Why? _____

Briefly describe you child's current academic difficulties (if any):_____

_____

When was the problem first noticed? _____

At what level do you feel your child is functioning academically compared to other children his/her age? _____

Has your child ever been:

☐ Suspended from school Number of Suspensions: _____

☐ Expelled from school Number of Expulsions: _____

Has your child ever been in any of the following educational programs, and if so, how long?

	Age(s) or Dates of Placement	Frequency of Intervention
☐ Gifted and Talented	_____	
☐ Section 504 services	_____	_____
☐ Content Mastery	_____	_____
☐ Resource Room Services	_____	_____
☐ Self-Contained Class	_____	
☐ Life Skills Class	_____	
☐ Behavioral/Emotional Disorders Class	_____	
☐ Counseling	_____	_____

Have any instructional modifications been attempted?

☐ Preferential seating ☐ Additional instructions

☐ FM system ☐ Peer teaching

☐ Increased positive feedback ☐ Reduced paper and pencil work

☐ Manipulatives in math ☐ Repeated review

☐ Extended time to complete assignments ☐ Outlines

☐ Shortened or modified assignments ☐ Positive reinforcers

☐ Study Sheets ☐ Behavior check cards / charts

☐ Control of distractions ☐ Predictable routines and classroom rules

☐ Behavior modification program ☐ Other _____

☐ Technologic assistance (word processor, calculator, augmentative communication device, etc.)

Main Line Neuropsychology, PLLC
Jennifer Badgley, PhD
Office Location: 30 S. Valley Road, Suite 207, Paoli, PA 19301
Mailing Address: 43 Paoli Plaza #1448, Paoli, PA 19301
Phone: 610.500.4700 Fax: 484.585.1673

ADDITIONAL COMMENTS:

Have any blood relatives of your child experienced problems similar to those your child is currently experiencing?

☐Yes ☐ No If Yes, please describe

Please write any additional remarks you may have regarding your child or address any area or concern we may have missed in the space provided:

Parent Printed Name: _____

Parent Signature: _____Date: _____