

Full Legal Name: _____ Date of Birth: _____ Age: _____
 Primary Language: _____ Race/Ethnicity: _____
 Gender at Birth: _____ Identified Gender: _____
 Sexual Orientation: _____ Dominant Hand: _____
 Person Completing Form: _____ Relationship to Patient: _____

Please provide a summary of your understanding of the reason for your referral, as well as the symptoms/concerns that led to the initiation of Neuropsychological Testing: _____

PRIMARY REASON FOR REFERRAL

Primary Symptoms	Severity of Symptom
	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Very Severe <input type="checkbox"/> Exceedingly Severe <input type="checkbox"/> Completely Debilitating
	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Very Severe <input type="checkbox"/> Exceedingly Severe <input type="checkbox"/> Completely Debilitating
	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Very Severe <input type="checkbox"/> Exceedingly Severe <input type="checkbox"/> Completely Debilitating
	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Very Severe <input type="checkbox"/> Exceedingly Severe <input type="checkbox"/> Completely Debilitating
	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Very Severe <input type="checkbox"/> Exceedingly Severe <input type="checkbox"/> Completely Debilitating

FAMILY INFORMATION

Please include all family members whether they be biological, adoptive, step etc.

Family Member	First Name	Biological/Step/Adopted	Age	Occupation/Grade	Custody Agreement. Living arrangement (with patient 100%, 50%, 0% Contact etc.)
Mother					
Father					
Step/adoptive mother					
Step/adoptive Father					

Sibling:					
Sibling:					
Sibling:					
Other:					
Other:					
Other:					

Please list the moves/relocations the patient has experienced since birth (If Any):

Moved From (City, State)	Moved To (City, State)	Age of pt

Custody/Guardianship

Are the patients' biological parents separated? Yes No If yes, how old was the patient at the time of separation? _____

Please describe the patient's custody status since birth.

Primary Custodian	Secondary Custodian	Time frame of custody	Age of patient	Was Custody mandated by an outside entity (court, OCS, Tribe etc.)?

Religion

Is the patient active in a religious practice? Yes No If yes, which religion: _____

How active is the patient with religion? Daily Weekly Monthly 3-4 times/year
 1-2 times a year Yearly N/A

Has the patient actively participated in other religions? Yes No If yes, which religion(s) and when:

BIRTH HISTORY

Please select the way in which the patient was delivered.

- | | | |
|--|---|---|
| <input type="checkbox"/> Vaginal Birth | <input type="checkbox"/> Forceps Used | <input type="checkbox"/> Emergency Cesarean |
| <input type="checkbox"/> Induced Labor | <input type="checkbox"/> Planned Cesarean | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Beech Birth | | |

Duration of Labor? _____ Apgar Scores: _____ Birth Weight: _____ Birth Length: _____

Was the patient born premature? Yes No (If Yes) How many weeks early? _____

Was the patient admitted to the NICU? Yes No (If Yes) For How Long? _____

Are you aware of any complications that occurred during/at the time of the patient's birth?

- | | | |
|---|---|---|
| <input type="checkbox"/> Labor did not progress | <input type="checkbox"/> Needed Oxygen | <input type="checkbox"/> Brain Bleed |
| <input type="checkbox"/> Abnormal Heartrate | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Umbilical Cord Issues | <input type="checkbox"/> Extended Hospital Stay | <input type="checkbox"/> Immature Lungs |
| <input type="checkbox"/> Blood Transfusion(s) | | |

Other:

Are you aware of any medical problems/conditions the patients birth mother experienced while pregnant with (i.e., gestational diabetes, hospitalizations, surgeries, etc.)? _____

Are you aware of any substance abuse by the patient's birth mother while pregnant? Yes No

(If Yes) What substance(s): _____
How Much? _____

INFANCY/TODDLER

Did the patient experience any delays in meeting your developmental milestones? Yes No

(If yes) what was the delay? Speech/Language Toilet Training Motor skills Walking

Other: _____

Medical Concerns

Prior to 4 years of age did the patient experience any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Delayed Growth | <input type="checkbox"/> Surgical Interventions | <input type="checkbox"/> Childhood Meningitis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Ear pain or infections | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Malnourished Severe | <input type="checkbox"/> Impaired Hearing | <input type="checkbox"/> Ear Tubes |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Impaired Vision | |

Other Medical Conditions: _____

Any other concerns or experiences that occurred prior to 4 years of age that you feel has affected the patient's life negatively in any way?

Head Trauma/Concussions/Brain Injury

Has the patient experienced any trauma to the head, concussion or other potential brain injury?
 Yes No

If Yes, then please answer the following:

How many head injuries? _____ At what age(s), (respectfully)? _____

Did any of the injuries result in loss of consciousness? Yes No If Yes:

How many times? _____ At what age(s), (respectfully)? _____

Behavioral Concerns

Prior to 4 years of age did the patient experience any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Easy to anger | <input type="checkbox"/> Picky Eating Habits | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Frequent tantrums | <input type="checkbox"/> Frequently forgetful | <input type="checkbox"/> Difficulty with change |
| <input type="checkbox"/> Property destruction | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Difficulty with authority |
| <input type="checkbox"/> Violence towards others | <input type="checkbox"/> Social Isolation | <input type="checkbox"/> Sensitive to Sound |
| <input type="checkbox"/> Trouble with attention | <input type="checkbox"/> Separation Anxiety | <input type="checkbox"/> Sensitive to Touch |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Frequent nightmares | |

Other behavioral concerns during this time: _____

Between the ages 5-10 did the patient experience/exhibit any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> N/A | | |
| <input type="checkbox"/> Easy to anger | <input type="checkbox"/> Social Isolation | <input type="checkbox"/> Self-Injurious Behavior |
| <input type="checkbox"/> Frequent tantrums | <input type="checkbox"/> Separation Anxiety | <input type="checkbox"/> Poor Impulse Control |
| <input type="checkbox"/> Property destruction | <input type="checkbox"/> Frequent nightmares | <input type="checkbox"/> Failure to respond to discipline |
| <input type="checkbox"/> Violence towards others | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Difficult Social Interactions |
| <input type="checkbox"/> Trouble with attention | <input type="checkbox"/> Difficulty with change | <input type="checkbox"/> Sexualized Behavior |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Difficulty with authority | <input type="checkbox"/> Low Self Esteem |
| <input type="checkbox"/> Picky Eating Habits | <input type="checkbox"/> Lying | <input type="checkbox"/> Quick to blame others |
| <input type="checkbox"/> Frequently forgetful | <input type="checkbox"/> Compulsion to need screen time | |
| <input type="checkbox"/> Anxiety | | |

Other behavioral concerns during this time: _____

Between the ages 11-15 did the patient experience/exhibit any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> N/A | | |
| <input type="checkbox"/> Easy to anger | <input type="checkbox"/> Frequent nightmares | <input type="checkbox"/> Sexualized Behavior |
| <input type="checkbox"/> Frequent tantrums | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Low Self Esteem |
| <input type="checkbox"/> Property destruction | <input type="checkbox"/> Difficulty with change | <input type="checkbox"/> Quick to blame others |
| <input type="checkbox"/> Violence towards others | <input type="checkbox"/> Lying | <input type="checkbox"/> Refusal to comply with authority |
| <input type="checkbox"/> Trouble with attention | <input type="checkbox"/> Compulsion to need screen time | <input type="checkbox"/> Lack of empathy |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Self-Injurious Behavior | <input type="checkbox"/> Running away from home |
| <input type="checkbox"/> Picky Eating Habits | <input type="checkbox"/> Poor Impulse Control | <input type="checkbox"/> Skipping School |
| <input type="checkbox"/> Frequently forgetful | <input type="checkbox"/> Failure to respond to discipline | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Anxiety | | <input type="checkbox"/> Vandalism |
| <input type="checkbox"/> Social Isolation | <input type="checkbox"/> Difficult Social Interactions | |
| <input type="checkbox"/> Separation Anxiety | | |

Other behavioral concerns during this time: _____

Was the patient ever hospitalized as a result of any of the referenced head injuries? Yes No If yes, please explain: _____

PERSONAL MEDICAL HISTORY

Height: ____ feet ____ inches

Weight: _____ pounds

Eyesight: Does the patient require corrective lenses or contacts? Yes No (If Yes) Do the lenses or contacts fully correct the impairment? Yes No Please explain: _____

Hearing: Does the patient have a hearing impairment? Yes No (If yes)? Does the patient have any type of implant or hearing device? Yes No Please explain: _____

Eating/Appetite: Has the patient had any type of significant weight gain or wight loss within the last year? Yes No Please explain: _____

Does the patient exhibit any of the following behaviors regarding food?

- Picky Eating Habits
- Continual Hunger
- Hiding Food
- Binge Eating
- Refusal to Eat
- Rapid Appetite Fluctuations
- Texture/Color/appearance-based food preferences or refusals

Sleep: On an average night, how would you describe the patient's sleep:

- Heavy/Deep
- Light
- Broken/Wakes Up a Lot
- Restless
- Difficulty getting to sleep
- Frequent Nightmares
- Other: _____

Please Explain: _____

What time does the patient typically go to bed: _____ Wake-Up: _____
 Has the patient ever completed a sleep study? Yes No If yes, please list the name of the clinic and the provider: _____

Surgery: Please list any past surgical procedures:

Surgery	Date of Surgery	Hospital/Clinic	Doctor/Surgeon	Complications
				<input type="checkbox"/> Yes <input type="checkbox"/> No

				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you listed yes to complications, please explain here: _____

Hospitalizations: Please list any past overnight hospitalizations

Reason for Hospitalization	Dates Inpatient	Hospital/Clinic	Complications	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you listed yes to complications, please explain here: _____

Medication: Please list all medications the patient is currently taking:

Medication Name	Dosage	Frequency which it is taken	Date when 1 st prescribed	Prescribed for	Prescribing Doctor

Please list all supplements the patient is currently taking:

Supplement Name	Dosage	Frequency which it is taken	Date when 1 st started taking	Taken for

Please list all psychiatric medications the patient has taken in the past:

Medication Name	Dosage	Frequency which it is taken	Prescribed for	Reason for stopping	Prescribing Doctor

Psychiatric

Please check all current and previous psychiatric conditions that patient has or is currently experiencing:

ADHD	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Insomnia	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Difficulty Paying Attention	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Fatigue	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Anxiety	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Difficulty Staying Asleep	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Feelings of Panic	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Frequent Nightmares	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Panic Attacks	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Loss of Appetite	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Social Anxiety	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Binge Eating	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Depression	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Over-Eating	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Bipolar Disorder	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Anorexia	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Periods of Mania	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Bulimia	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Periods of Hypomania	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Suicidality	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Schizophrenia	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Self-Deprecating Thoughts	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Emotional Dysregulation	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Self-Harm	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Obsessive Compulsive Disorder	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Homicidal Thoughts	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Debilitating Phobias	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Chronic Headaches	<input type="checkbox"/> Current	<input type="checkbox"/> Past
Noise sensitivity	<input type="checkbox"/> Current	<input type="checkbox"/> Past	Intermittent dizziness	<input type="checkbox"/> Current	<input type="checkbox"/> Past

Please describe any other psychiatric conditions or symptoms that the patient currently or has previously experienced: _____

Please list all current or previously diagnosed psychiatric conditions:

Diagnosis	Age of diagnosis	Provider who made diagnosis	Current or Previous
			<input type="checkbox"/> Current <input type="checkbox"/> Previous
			<input type="checkbox"/> Current <input type="checkbox"/> Previous
			<input type="checkbox"/> Current <input type="checkbox"/> Previous
			<input type="checkbox"/> Current <input type="checkbox"/> Previous

Additional Information: _____

SUBSTANCE USE/ABUSE HISTORY (If applicable)

Please list any/all substances the patient has used/consumed:

Substance	Frequency of use (Daily/weekly/socially, etc.)	Average amount used/consumed	Age 1 st exposed	Date of last use	Date stopped/quit (if applicable)

Caffeine					
Tobacco/Nicotine					
Alcohol					
Marijuana					
Opioids/Prescription Drugs					
Inhalants					
Hallucinogens (Mushrooms, LSD)					
Amphetamines/Stimulants (Crack, Cocaine, meth)					
Other: _____					

Has the patient experienced any legal problems due to consumption/use of substances? Yes No If yes, which substance(s)? _____

Please Explain: _____

FAMILY MEDICAL HISTORY

Condition	Person(s) who was/is affected by condition	Maternal or Paternal Side
Cancer	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
High Blood Pressure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Stroke	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Diabetes	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
High Cholesterol	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Blood Disorder/Disease	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Heart Problems/Disease	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Kidney Problems/Disease	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal

Liver Problems/Disease	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Lung Problems/Disease	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Alzheimer's Disease	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Dementia	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Seizure Disorder	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Sleep Disorder	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Thyroid Disorder	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Multiple Sclerosis	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Parkinson's Disease	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Huntington's Disease	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Other Neurological Disorder(s) - _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Other Genetic Disorder(s) - _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal

Please list any other significant family medical history that is not listed above and/or please provide any significant details regarding any of the responses above: _____

FAMILY PSYCHIATRIC HISTORY

Condition	Person(s) who was/is affected by condition	Maternal or Paternal Side
ADHD	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Anxiety	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Depression	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal

Bipolar Disorder	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Obsessive Compulsive Disorder	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Schizophrenia	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
PTSD	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Autism	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Learning Disabilities	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Speech/Language Disorder(s)	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Drug Abuse/Addiction	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Alcoholism	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Other behavioral problems/disorders – _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> First Cousin	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal

Please list any other significant family psychiatric history that is not listed above and/or please provide any significant details regarding any of the responses above: _____

SCHOOL/EDUCATION

List the schools the patient has attended from preschool current:

School Name	Public or Private	City	State	Grades Attended

Has the patient ever been suspended/expelled? _____ Yes No How Many Times? _____

Please explain: _____

How much time does to patient allocate to homework each day? _____ How much of that time does the patient need assistance? _____

What is the patient's general opinion about school?

- Loves it
- It is ok
- Neutral

- Likes it only for the socialization
- Dislikes it
- Has to be forced/bribed to go

Educational Modifications/Supports: Please check the following that applied to the patients experience in school.

- IEP.
If yes, what grades(?) _____
- 504
If yes, what grades(?) _____
- Held back.
If yes, what grades(?) _____
- Skip grade(s).
If yes, what grades(?) _____

- Disorganization
- Talking Too Much
- Interrupting Others
- Frequently Late
- Missing Assignments
- Special Education Classes
- Diagnosed Learning Disability
- Speech Therapy

- Poor/Failing Grades
- Repeated Classes/Summer School
- Tutoring
- Lack of Motivation
- Problems Concentrating
- Gifted Program
- Poor Time Management

Other modifications or supports the patient has in school? _____

Other factors that detracted from the patient's ability to be successful in school? _____

Does the patient do any recreational reading? Yes No How Many Minutes Per Week? _____

How often is the patient read to by a family member? _____ minutes per week.

What would you consider the patients strongest academic area(s)? _____

What would you consider the patients weakest academic area(s)? _____

Extracurricular activities the patient participates in (Sports, Music, Arts, Clubs etc.): _____

Current Behavioral Concerns: Please check any of the boxes below that you are currently concerned about in regards to the patient.

- | | | |
|--|---|--|
| <input type="checkbox"/> Easy to angry | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Frequent tantrums | <input type="checkbox"/> Difficulty with change | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Property destruction | <input type="checkbox"/> Difficulty with authority | <input type="checkbox"/> Memory concerns |
| <input type="checkbox"/> Violence towards others | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Lack of Empathy |
| <input type="checkbox"/> Trouble with attention | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Inability to accept change |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Poor Self-Esteem | <input type="checkbox"/> Inappropriate friends/relationships |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Sexual Trauma/Abuse | <input type="checkbox"/> Inappropriate sexualized behavior |
| <input type="checkbox"/> Frequently forgetful | <input type="checkbox"/> Physical Trauma/Abuse | <input type="checkbox"/> Inappropriate Amount of Screen Time |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Often Tearful | <input type="checkbox"/> Distorted Body Image |
| <input type="checkbox"/> Social Isolation | <input type="checkbox"/> Constant Whining | |
| <input type="checkbox"/> Separation Anxiety | <input type="checkbox"/> Lack of special/body awareness | |
| <input type="checkbox"/> Frequent nightmares | <input type="checkbox"/> Oppositional defiance | |

Does the patient require disciplinary interventions? Yes No If yes, what type of discipline is implemented? _____

How does the patient respond to discipline? _____

Social/Recreational

Please list any leisure activities/hobbies the patient enjoys: _____

Please list any sporting/recreational activities the patient participates in: _____

Please list any additional areas of interest talent or topics that the patient is very knowledgeable about: _____

Please list any family activities the patient enjoys participating in: _____

Please check the following that applies to the patient's social situation:

- | | |
|--|---|
| <input type="checkbox"/> Small (3-5) consistent friend group | <input type="checkbox"/> Friends did not attend same school |
| <input type="checkbox"/> Large social network | <input type="checkbox"/> Little to no social interactions |
| <input type="checkbox"/> 1-2 close friends | <input type="checkbox"/> Did not enjoy socializing |

What are the patients' main social deficiencies when it comes to getting along with others and/or making new friends? _____

What are the patient's main responsibilities/chores at home? _____

Does the patient have difficulty completing these? _____

ADDITIONAL INFORMATION:
