NEUROBEHAVIORAL ASSOCIATES

Specializing in Attention, Learning, and Neurodevelopmental Differences

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CHILD

Providing: Neuropsychological Consultation & Evaluation
Educational Consultation
Referral Services

To the Parents of:

_____

Welcome to NeuroBehavioral Associates

We are pleased to offer you and your family a full range of comprehensive neuropsychological and psychological assessment services. The neuropsychological evaluation is one method of diagnosing developmental, degenerative, and acquired disorders of brain function. Neuropsychological evaluation can help determine the impact and consequences of brain-based disorders. The purpose of the neuropsychological examination is to assess how dysfunction of the brain may relate to problems in thinking, learning, emotions, and/or behavior.

We specialize in the assessment of **Attention, Learning,** and **Neurodevelopmental Differences**. Our evaluation includes intellectual assessment, assessment of attention and concentration, visual motor skills, memory and processing skills, executive abilities, and emotional/personality functioning.

You have an appointment for neuropsychological consultation and/or evaluation with:

Dr. _____

Consultation (if needed) Date: _____ Time: _____

Evaluation Date: _____ Time: _____

Your full financial obligation to our office at this time is $ _____. **The full payment is due at the time of your visit.** You may pay by cash, personal check, money order, or credit card. We do not accept debit cards. Additional services, such as attendance at IEP or 504 meetings, school observations and document preparation are billed separately.

We will provide information to permit insurance submission. We ask that you confirm with your insurance company if pre-authorization is necessary prior to your appointment.

Please fill out the enclosed history form and bring it with you at the time of the appointment. Also, please bring **photocopies of relevant academic or medical records, for our files** as well. **Should you need to cancel your appointment for any reason, please notify this office at least 48 hours in advance**. If notification is not made in advance, you may be charged for one hour of service.

We look forward to serving you.

Thank you,

Vincent P. Culotta, Ph. D., ABN
Licensed Psychologist
Neuropsychologist

Visit our website at www.nbatests.com !
www.facebook.com/nbacolumbia

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CHILD/ADOLESCENT HISTORY FORM

Child's Name: _____

Date of Birth: _____

_____ Age: _____

Pediatrician: _____

Referral Source: _____

REASON FOR CONSULTATION: _____

_____

_____

_____

_____

_____

EDUCATIONAL HISTORY:

School: _____ Grade: _____

Special Services: _____ Level: _____

Has any School or Professional given any of the following Diagnoses?

Diagnosis	By Whom?	When?
Communication Disorder:	_____	_____
Autism/PDD	_____	_____
Intellectual Disability:	_____	_____
ADD/ADHD:	_____	_____
Emotional Disturbance:	_____	_____
Reading Disability:	_____	_____
Math Disability:	_____	_____
Writing Disability:	_____	_____
Coordination Disorder:	_____	_____
Hearing Impaired:	_____	_____
Visually Impaired:	_____	_____
Other: _____	_____	_____

Age at Kindergarten Entry: _____ Retention in Grade: _____

Reported Reading Level: _____

Reported Academic Problems: _____

_____

_____

Reported School Behavior Problems (Please Check):

Fidgets		Walks around classroom	
Doesn't wait his/her turn		Cooperates poorly in groups	
Does better one-to-one		Poor attention	
Aggressiveness towards students		Doesn’t respect the rights of others	
Aggressiveness towards teachers		Fails to complete assigned work in school	
Fails to complete homework		Other:	

BEHAVIORAL HISTORY:

Do you notice any of the following in your child? (Please Check):

Problems making friends		Problems keeping friends	
Inappropriate friends		Hyperactivity	
Poor attention span		Impulsivity	
Temper outbursts		Low frustration tolerance	
Sloppy table manners		Frequent interruptions	
Doesn't listen		Doesn't understand directions/Instructions	
Gets "wired"		Physically aggressive	
Fails to learn from experience		Wears out shoes/clothing unusually fast	
Frequent accidents		Poor memory	
Seems different or odd		Grinds teeth	
Distractible		Wanders	
Runs away		Truant	
Starts fires		Plays with matches	
Pica (eats non-food)		Fidgets	
Wets		Fecal Soiling	
Breaks things by accident		Breaks things intentionally	
Excessive lying		Hard on toys	
Cruel to animals		Rocks	
Sucks thumb or fingers		Chews on clothing or other objects	
Bites nails or fingers		Repetitive purposeless behavior	
Self injurious behavior		Tics or funny movements	
Drug experimentation		Regular drug use	

Parental Estimate of Intelligence: _____

Parental Impression of Behavior: _____

_____

_____

PSYCHIATRIC HISTORY:

Current Therapist: _____

Current Psychiatrist: _____

Current Diagnosis: _____

Prior Treatment: _____

Prior Diagnosis: _____

Psychiatric Hospitalization: _____

Suicide Threat: _____ Suicide Attempt: _____

Current Medications: _____

_____

_____

Prior Medications: _____

_____

_____

GESTATIONAL / MEDICAL HISTORY: (Please answer yes or no and explain)

Length of Pregnancy: _____ Birth Weight: _____ APGAR Score: _____

Pregnancy Complications:

Excessive Vomiting: When: _____ Medication: _____

Maternal Hospitalization: When: _____ Reason: _____

Maternal Weight Loss: When: _____ Lbs. Lost: _____

Staining/Bleeding: When: _____ Cause: _____

Premature Labor: When: _____ Treatment: _____

Premature Rupture

of Membranes: When: _____ Treatment: _____

Prenatal Care: _____

Maternal Infection: _____

High Blood Pressure: _____

Toxemia: _____

Preeclampsia: _____

Maternal Medication: _____

Reason: _____

Surgical Procedures: _____

Toxic/Industrial Chemical Exposure: _____

Smoking/Amount: _____

Alcohol Consumption/Amount: _____

X-Rays: _____

Prior Birth Control: _____

Planned Pregnancy?: _____

Spontaneous Labor?: _____

Route of Delivery: _____

Forceps Used: _____

Labor Delivery Medication: _____

Fetal heart Decelerations: _____

Respiratory Problems at Birth: _____

Color of Infant at Birth: _____

Immediate Cry: _____

Oxygen by Mask: _____

Oxygen by Tube: _____

Intubation/Ventilator: _____

Jaundice: _____

Treatment: _____

Breathing Problems after Birth: _____

Infections: _____

Seizures: _____

Hemorrhage in Brain: _____

Birth Defects: _____

Other: _____

During Infancy was your Baby?:

Colicky: _____ Time of Day: _____ Until What Age: _____

Cuddly: _____ Responsive to Touch: _____

Restless: _____ Poor Sleeper: _____

Head Banger: _____ Irritable: _____

Floppy: _____ Stiff: _____

Method of Feeding: _____ Feeding Problems: _____

Weight Gain: _____ General Health: _____

Does your child have a history of?:

Measles: _____ Mumps: _____

Chicken Pox: _____ Cuts with Stitches: _____

Broken Bones: _____ Operations: _____

Hospitalizations: _____

Head Injuries: _____ Coma: _ Seizures without Fever: _____

Seizures with Fever: _____ Vision Problems: _____

Persistent High Fevers: _____ Percent Hearing Test Results: _____

Hearing Problems: _____ PE Tubes: _____

Frequent Ear Infections: _____ Adenoidectomy: _____

Tonsillectomy:_____ Severe Reaction to Immunizations: _____

Frequent Strep: _____ Respiratory Problems: _____

Asthma: _____

Allergies: _____

Other Serious Illnesses: _____

Accidental Poisoning: _____

Sleep Problems:_____Poor Appetite: _____

Physical Abuse:_____Sexual Abuse: _____

Current Height: _____Weight: _____

Current Medications: _____

Other:_____

Gross Motor Coordination: _____

Hand/Eye Coordination: _____

Handwriting Problems: _____

DEVELOPMENTAL HISTORY (Note approximate AGE for each item.)

Smiled: _____Sat Alone: _____

Turned Back to Front:_____Turned Front to Back: _____

Crawled: _____

When crawling, did your child get his/her stomach off the floor? _____

Did he/she drag either side of the body? _____

Stood Alone: _____Walked Alone: _____

First Words other than Mama or Dada: _____

Two Word Phrases: _____

Sentences: _____

_____

_____

Urine Training Day:_____ Urine Training Night: _____

Bowel Training Day:_____ Bowel Training Night: _____

Rode Two-Wheeler: _____ Dress Self Except Shoes: _____

Tied Shoes: _____

FAMILY/PSYCHOLOGICAL HISTORY:

Mother:

Age at time of birth: _____ Current Occupation: _____

Years of Education/Highest Grade or Degree: _____

History of Learning Problems: _____

History of Slow/Abnormal Development: _____

History of Behavior Problems: _____

History of Psychiatric/Psychological Problems: _____

Hospitalizations:_____

Current Chronic/Serious Medical Problems: _____

Current Medications: _____

Total Number of Pregnancies: _____ Number of Live Births: _____

Miscarriages:_____ Therapeutic Abortion: _____

Father:

Age at time of birth: _____ Current Occupation: _____

Years of Education/Highest Grade or Degree: _____

History of Learning Problems: _____

History of Slow/Abnormal Development: _____

History of Behavior Problems: _____

History of Psychiatric/Psychological Problems: _____

Hospitalizations:_____

Current Chronic/Serious Medical Problems: _____

Current Medications: _____

Siblings and Half Siblings (note relationship)**:**

Age: _____ Gender: _____ Relationship: _____

School Problems: _____

Developmental Problems: _____

Medical Problems: _____

Behavior Problems: _____

Age: _____ Gender: _____ Relationship: _____

School Problems: _____

Developmental Problems: _____

Medical Problems: _____

Behavior Problems: _____

Age: _____ Gender: _____ Relationship: _____

School Problems: _____

Developmental Problems: _____

Medical Problems: _____

Behavior Problems: _____

Biological Mother:

Marital Status: _____ Years Married: _____

Years Living Together: _____ Years Separated: _____

Age of Child at Divorce: _____

Custody Agreements: _____

Biological Father:

Marital Status: _____ Years Married: _____

Years Living Together: _____ Years Separated: _____

Age of Child at Divorce: _____

Custody Agreements: _____

Remarriage of Mother:

Age of Child at Remarriage:

(Please note age of siblings)

Step Siblings:	Half Siblings:

Age of Child of Remarriage:

(Please note age of siblings)

Step Siblings:	Half Siblings:

Persons Living in Home with Child: (Please Check)

Biological Mother		Biological Father	
Adoptive Mother		Adoptive Father	
Biological Siblings		Stepmother	
Stepfather		Step-siblings	
Other			

Child Care Arrangements: _____

_____

_____

Languages other than English at Home or in Child Care: _____

_____

EXTENDED FAMILY HISTORY: (Include Child's Grandparents, Great Aunts and Uncles, and First Cousins. Identify Side of Family; Maternal or Paternal)

Seizures: _____

_____

Intellectual Disability: _____

_____

Attention Deficit Disorder: _____

_____

Learning Disabilities: _____

_____

Illiteracy/School Drop Out: _____

_____

Communication Disorder: _____

_____

Autism/PDD: _____

_____

Depression: _____

Bipolar Illness: _____

_____

Schizophrenia: _____

_____

Tics or Involuntary Movements: _____

_____

Anxiety: _____

_____

Obsessive-Compulsive Behaviors: _____

_____

Psychiatric Hospitalization: _____

_____

Drug Abuse: _____

_____

Alcoholism: _____

_____

Thyroid Problems: _____

_____

Genetic Diseases: _____

_____

Cerebral Palsy: _____

_____

Frequent Miscarriages or Stillbirths: _____

_____

Death Before the Age of One: _____

_____