Dr Lee Hearn
Clinical Psychologist & Clinical Neuropsychologist

Background Information Form
Neuropsychology and Clinical Psychology

Child's Name: _____ Gender: _____

Date of Birth: _____ Age: _____

Who currently lives at home with your child?

Name	Age	Gender	Relationship to child

Does the child have any other siblings/half siblings who live elsewhere? If yes, list name, age and gender:

_____

_____

_____

Custody arrangements (if applicable): _____

What schools has your child attended?

	Name of School / Centre	Dates	Grades
Out of home care (e.g. Day Care)			
Preschool			
Primary			
High School			

Please describe your child's strengths:

Please describe the concerns you have about your child:

Please write down your goals for seeing a Psychologist:

Please rate your child's current functioning in the following areas:

	Below Average	Average	Above Average
Social	☐	☐	☐
Emotional	☐	☐	☐
Intellectual	☐	☐	☐
Physical	☐	☐	☐
Language	☐	☐	☐
Behavioural	☐	☐	☐

Please provide details of any previous assessments that have been carried out (e.g. cognitive assessments, speech pathology assessments, etc.)?

TEST	DATE	RESULTS

Please bring the results of any previous testing with you to the initial consultation.

Developmental History:

Were there any complications during the pregnancy (e.g. maternal illness, etc)?

_____

_____

Term length: ☐ Full ☐ Premature ___ (wks) ☐ Late ___ (wks) Birth weight _____

Any complications during birth: _____

Did your child experience any issues after birth (e.g. jaundice, seizures etc)?

_____

_____

Describe your child's temperament as an infant (e.g. placid, active, demanding etc): _____

_____

Did your child experience difficulties in any of the following areas during infancy or early childhood?:

☐ Social	☐ Physical Development	☐ Cognitive Development
☐ Emotional	☐ Behavioural	☐ Toilet Training
☐ Difficulty with separation	☐ Sleeping	☐ Eating

Details: _____

_____

_____

At approximately what age were the following milestones achieved:

Sitting: _____ Crawling: _____ Walking: _____ Talking:_____

List any significant or traumatic events that occurred during infancy or early childhood (e.g.. birth of sibling, death of family member, physical or sexual abuse, separation from parent, divorce etc):

_____

_____

Primary School Years:

List any difficulties during this time (e.g. social, emotional, behavioural, physical and cognitive development, difficulties starting school, or difficulties with separation)

_____

_____

_____

_____

High School Years:

List any difficulties during this time (e.g. difficulty transitioning to high school, difficulties with relationships with peers, parents or teachers, bullying, issues with academic performance, etc)

_____

_____

_____

_____

Has your child received any special education assistance? ☐ Yes ☐ No

If yes, please provide details: _____

_____

_____

Medical History

Does your child have any current medical conditions, illnesses or allergies? ☐ Yes ☐ No

Details: _____

_____

_____

Has your child's hearing been tested? ☐ Yes ☐ No Were any issues identified: ☐ Yes ☐ No

Details: _____

Has your child's vision been tested? ☐ Yes ☐ No Were any issues identified: ☐ Yes ☐ No

Details: _____

Current medications your child takes (please list all):

Name or type of medicine	Dose	Frequency	Who prescribes this medication
1			
2			
3			
4			

Has your child previously experienced any serious injuries, illnesses, or surgery? ☐ Yes ☐ No

If yes, provide details and approximate dates: _____

_____

_____

Family History

Is there any family history of psychological, developmental or learning difficulties? ☐ Yes ☐ No

If yes, please provide details:

_____

_____

_____

Psychological Treatment History

Has your child previously consulted a professional for any emotional or behavioural issues? ☐ Yes ☐ No

If yes, please provide details:

_____

_____

_____

_____

Social Functioning

How does your child spend his/her free time?_____

_____

_____

What type of playmates does your child prefer (tick all that apply):

☐ Older ☐ Younger ☐ Own age ☐ All ages ☐ Adults

How many friends does your child have? _____

Does your child have a best friend? ☐ Yes ☐ No. If yes, how long have they been friends: _____

Does your child have trouble making or keeping friends? ☐ Yes ☐ No

If yes, please provide details: _____

_____

_____

_____

Perceptions of the Issues

What do you think is contributing to your child's current presenting problems (e.g. recent change of school, etc.)?

_____

_____

_____

_____

_____

_____

Please provide information about anything else that you think is important regarding your child

_____

_____

_____

_____

_____

_____

Is there any sensitive information that you would prefer not to discuss in front of your child?

☐ Yes ☐ No

If yes, we can discuss these issues while your child waits outside. You may wish to bring a book or something for them to do while they wait.

Thank you for taking the time to complete this questionnaire.

Completed by: _____ Date: _____