EPILEPSY INSTITUTE OF NORTH CAROLINA

Patient History and Background Information

Name: _____ **Date:** ____ /____ / 20_____

Preferred name: _____ Person completing form: _____

Reason For Assessment

What are your primary concerns regarding your child and/or specific questions you would like help with?

_____

_____

_____

When did you first become concerned about your child? _____

_____

_____

Early Developmental History

Is this child your biological child or adopted? ☐ *biological* ☐ *adopted*

If adopted, at what age did you adopt this child? _____, country of birth for this child: _____

Did the pregnancy have any complications? ☐ No ☐ Yes (explain) _____

_____

How long was the pregnancy? _____ Baby's birth weight: _____

Were there any difficulties caring for this child during the first year? ☐ No ☐ Yes _____

_____

Did you seek any services in the first 3 years? ☐ No ☐ Yes _____

_____

Please list the age your child reached the following milestones:

said first word _____ used simple sentences _____

sat up alone _____ crawled _____

walked alone _____ toilet trained during day _____

dry at night _____

Medical History

Currently prescribed medication(s)? ☐ No ☐ Yes

Medication	Dosage	Duration	Reason for use/Comments

Medical History

Check *No* or *Yes* for a history of any of the following, and explain if yes:

Allergies ☐ No ☐ Yes _____
Hearing problem ☐ No ☐ Yes _____
Vision problem ☐ No ☐ Yes _____
Hospitalization ☐ No ☐ Yes _____
Serious accident ☐ No ☐ Yes _____
Serious illness ☐ No ☐ Yes _____
Chronic illness ☐ No ☐ Yes _____
Seizure/febrile seizure ☐ No ☐ Yes _____
Tics ☐ No ☐ Yes _____
Night terrors ☐ No ☐ Yes _____

Check *No* or *Yes* for any of the following *current* concerns, and explain if yes:

Eating problems ☐ No ☐ Yes _____
Sleep problems ☐ No ☐ Yes _____
Bedwetting ☐ No ☐ Yes _____
Stomachaches ☐ No ☐ Yes _____
Headaches ☐ No ☐ Yes _____
Menstrual cycle ☐ No ☐ Yes _____

Check *No* or *Yes* for any of these services that your child is receiving, or has received in the past:

Speech/language therapy ☐ No ☐ Yes _____
Occupational therapy ☐ No ☐ Yes _____
Physical therapy ☐ No ☐ Yes _____
Counseling ☐ No ☐ Yes _____
Educational tutoring ☐ No ☐ Yes _____

Alcohol Usage: ☐ Currently Every Day ☐ Currently Some Days Amount:_____ Type: _____
☐ Former - Age Quit _____ ☐ Never

Tobacco Usage: ☐ Currently Every Day ☐ Currently Some Days Amount:_____ Type: _____
☐ Former - Age Quit _____ ☐ Never

Caffeine Usage: ☐ Currently Every Day ☐ Currently Some Days Amount:_____ Type: _____
☐ Never

Recreational Drug Usage: ☐ Currently Every Day ☐ Currently Some Days Type: _____
☐ Former - Type: _____ ☐ Never

Educational History

Name of current school: _____ Grade: _____

Circle if your child has any of the following: ☐ *504* ☐ *IEP*

If your child has an IEP, check the classification:

☐ ASD ☐ Dev Delay ☐ SED ☐ Hearing Impaired ☐ ID ☐ MD ☐ Ortho Impairment ☐ OHI ☐ SLD

☐ Speech or language Impairment ☐ TBI ☐ Visual Impairment including Blindness ☐ Deaf-blindness ☐ Deafness

If your child has an IEP, what services are provided: _____

_____

What grades, or GPA, does your child currently have? _____

Did your child ever repeat a grade? ☐ No ☐ Yes (which grade) _____

Please list all schools attended. List grades attended for each school. *If you home schooled your child for any of these years, please note this as well.*

Preschool: _____

Elementary: _____

Middle school: _____

High School: _____

Has your child had any testing through the school? ☐ No ☐ Yes (when)_____

Have you sought testing for educational concerns anywhere? ☐ No ☐ Yes (when)_____

Is homework completion an area of concern? ☐ No ☐ Yes (explain) _____

_____

Has the school contacted you about behavior concerns? ☐ No ☐ Yes (explain):_____

_____

Family Information

Who has legal guardianship of this child? _____

Please check parents' marital status: ☐ *Never married* ☐ *Married* ☐ *Separated* ☐ *Divorced* ☐ *Widowed*

If parents are separated, divorced, or widowed; when did this occur and age of child at the time:

_____

If parents are separated or divorced, please describe the custody arrangements:

_____

_____

If one of the parents is NOT living in the child's primary home, please explain the frequency of contact:

_____

_____

Please list all persons living in the child's primary home:

Name	Relationship to child	Age	Gender M / F	Highest grade completed/degree

If any immediate family member (e.g., parent, sibling) is living elsewhere, please list:

Name	Relationship to child	Age	Gender M / F	Highest grade completed/degree

Please check *No* or *Yes* for any of the following in the last year, and if yes, please explain:

Family relocate ☐ No ☐ Yes _____
Marital problems ☐ No ☐ Yes _____
Serious parent illness ☐ No ☐ Yes _____
Serious sibling illness ☐ No ☐ Yes _____
Serious accident to family member ☐ No ☐ Yes _____
Parent job difficulties/loss ☐ No ☐ Yes _____
Death of close family member ☐ No ☐ Yes _____

Please check *No* or *Yes* for a family history of the following. If *Yes*, list relation to child:

Learning difficulties ☐ No ☐ Yes _____
ADHD/ADD ☐ No ☐ Yes _____
Anxiety problems ☐ No ☐ Yes _____
Autism ☐ No ☐ Yes _____
Depression ☐ No ☐ Yes _____
Bipolar disorder ☐ No ☐ Yes _____
Suicide attempt ☐ No ☐ Yes _____
Drug/alcohol problem ☐ No ☐ Yes _____
"Nervous breakdown" ☐ No ☐ Yes _____
Schizophrenia ☐ No ☐ Yes _____
Any genetic syndrome ☐ No ☐ Yes _____
Seizure disorder ☐ No ☐ Yes _____
Thyroid problems ☐ No ☐ Yes _____
Type I Diabetes ☐ No ☐ Yes _____

If there is other information that you think will be helpful to us, please explain below:

_____
_____
_____
_____
_____
_____