ABBEY NEUROPSYCHOLOGY CLINIC
366 S. California Avenue, Suite 14
Palo Alto, CA 94306
Ph: 650-614-0014
Fax: 650-204-6502

NEW CLIENT INFORMATION SHEET (PARENT/CHILD)

Child's Name: ______________________________ **DOB:** __________________ **Age:** ________

Gender: _____

Home Address: ____
Street City State Zip

Home Phone: ________________________________

School: ____

School Address: ____
Street City State Zip

School Phone: _______________________________ **Teacher:** ___________________________

Name of adult completing form: ____

Relationship to child: ____

Parental Information

Mother's Name: ________________________________
Telephone: _______________________
Work::____________________________
Cell: ____________________________
Email: ___________________________

Address, if different from above: ____
Street City State Zip

Father's Name: ________________________________
Telephone: _______________________
Work: ____________________________
Cell: ____________________________
Email: ___________________________

Address, if different from above: ____
Street City State Zip

Emergency Contact Person: ___________________________ **Relationship:** __________________

Telephone: Home: ________________________________ Work: ______________________________
Cell: ________________________________

The child's parents are:

- ☐ Married/Committed relationship
- ☐ Separated
- ☐ Divorced
- ☐ Other: ____

ABBEY NEUROPSYCHOLOGY CLINIC
366 S. California Avenue, Suite 14
Palo Alto, CA 94306
Ph: 650-614-0014
Fax: 650-204-6502

If parents are separated or divorced, how old was the child when the separation occurred? ______________

If parents are not living together, what is the custody arrangement? ________________________________

Who meets the child's care and/or parenting needs? ____

Please list all people living in the household:

Name:___________________________ Age: _______ Relationship to child: _______________________

Name:___________________________ Age: _______ Relationship to child: _______________________

Name:___________________________ Age: _______ Relationship to child: _______________________

Name:___________________________ Age: _______ Relationship to child: _______________________

Name:___________________________ Age: _______ Relationship to child: _______________________

Name:___________________________ Age: _______ Relationship to child: _______________________

If siblings are living outside the home, please list their names and ages:

Name: __________________________ Age: ________

Name: __________________________ Age: ________

Name: __________________________ Age: ________

Name: __________________________ Age: ________

Name: __________________________ Age: ________

Religion(s) practiced in the home (if any): ____

Primary language spoken in the home: ______________________Other languages: _______________

ABBEY NEUROPSYCHOLOGY CLINIC
366 S. California Avenue, Suite 14
Palo Alto, CA 94306
Ph: 650-614-0014
Fax: 650-204-6502

REASONS FOR SEEKING EVALUATION OR THERAPY

Please provide a short description of the concerns that have brought you to the Abbey Neuropsychology Clinic:

____
____
____
____
____
____
____
____
____
____

How long has this problem(s) been occurring? ____________________

When was the problem first noticed? ____________________

What seems to help the problem (if anything)? ____________________
____

What seems to make the problem worse? ____________________
____

PRIOR TREATMENT

Has your child received evaluation or treatment for the current problem? **YES** **NO**
If yes, when, with whom, and what was the outcome?

____
____
____

Is your child currently taking any medication? **YES** **NO**

If yes, what medications: ____________________

Who referred you to us? ____________________

EDUCATIONAL HISTORY

Does your child have difficulty with any of the following?

- ☐ **Reading**
- ☐ **Arithmetic**
- ☐ **Spelling**
- ☐ **Writing**
- **Time management**
- **Social interactions**

ABBEY NEUROPSYCHOLOGY CLINIC
366 S. California Avenue, Suite 14
Palo Alto, CA 94306
Ph: 650-614-0014
Fax: 650-204-6502

Does your child like school?

What is your child's favorite subject? ______________________ Least favorite? ________________

Is your child in a special education class? YES NO

Has your child ever been held back a grade? YES NO

If yes, what grade and why? ____

Has your child ever skipped a grade? YES NO

Has your child ever received special tutoring or therapy in school? YES NO

If yes, please describe: ____

____

____

SOCIAL BEHAVIOR CHECKLIST

Does your child currently exhibit any of the following:

- ☐ Difficulty with speech
- ☐ Difficulty with hearing
- ☐ Difficulty with language
- ☐ Difficulty with vision
- ☐ Difficulty with coordination
- ☐ Nightmares
- ☐ Trouble sleeping
- ☐ Wets bed
- ☐ Bites nails
- ☐ Has blank spells
- ☐ Eats poorly
- ☐ Sucks thumb
- ☐ Holds breath
- ☐ Bangs head or other self-injurious behaviors
- ☐ Rocks back and forth
- ☐ Is clumsy
- ☐ Steals things
- ☐ Is slow to learn
- ☐ Has few friends
- ☐ Doesn't get along with siblings
- ☐ Is stubborn
- ☐ Has few friends
- ☐ Prefers to be alone
- ☐ Is shy or timid
- ☐ Is more interested in objects than people
- ☐ Gives up easily
- ☐ Talks back
- ☐ Is impulsive
- ☐ Is oppositional or defiant
- ☐ Is aggressive
- ☐ Has frequent tantrums
- ☐ Shows daredevil behavior

- ☐ Engages in behavior that could be dangerous t o him/herself (describe):

____

____

- ☐ Engages in behavior that could be dangerous to others (describe):

____

____

ABBEY NEUROPSYCHOLOGY CLINIC
366 S. California Avenue, Suite 14
Palo Alto, CA 94306
Ph: 650-614-0014
Fax: 650-204-6502

- ☐ **Has special fears, habits, or mannerisms (describe):** ____________________
- ☐ **Other:** ____________________

If your child has ever been in trouble with the law, please describe:

____

DEVELOPMENTAL HISTORY

During pregnancy, did the child's mother:

Take medication?	**YES**	**NO**	**If yes, what kind?** __________
Smoke cigarettes?	**YES**	**NO**	**If yes, how many per day?**__________
Drink alcohol?	**YES**	**NO**	**If yes, how much?** __________
Use drugs?	**YES**	**NO**	**If yes, what?**__________ **How often?**__________

Were forceps used?	**YES**	**NO**	
Cesarean section?	**YES**	**NO**	
Was the child premature?	**YES**	**NO**	**If yes, by how many weeks?** __________

What were the child's birth height and weight? ______**lbs**____**ounces** ______________**in.**

Please describe any birth defects or complications:

____

Please describe any feeding or sleeping problems:

____

Please describe any growth or development problems:

____

ABBEY NEUROPSYCHOLOGY CLINIC
366 S. California Avenue, Suite 14
Palo Alto, CA 94306
Ph: 650-614-0014
Fax: 650-204-6502

Did your child meet developmental milestones within normal timelines? YES NO
If NO, please explain:

____
____
____
____

CHILD'S MEDICAL HISTORY

Place a check next to any illness or condition that your child has had. When you check an item, also note the approximate age of onset of any illness:

	Illness/Condition	Age(s) of Onset		Illness/Condition	Age(s) of Onset
_____	Measles	__________	_____	Dizziness	__________
_____	German measles	__________	_____	Frequent/severe headache	__________
_____	Mumps	__________	_____	Weakness	__________
_____	Chicken Pox	__________	_____	Memory problems	__________
_____	Whooping cough	__________	_____	Extreme fatigue	__________
_____	Diptheria	__________	_____	High fever	__________
_____	Scarlet fever	__________	_____	Convulsions	__________
_____	Meningitis	__________	_____	Fainting	__________
_____	Encephalitis	__________	_____	Paralysis	__________
_____	Rheumatic fever	__________	_____	Vision loss	__________
_____	Epilepsy	__________	_____	Hearing loss	__________
_____	Tuberculosis	__________	_____	Head injury	__________
_____	Diabetes	__________	_____	Suicide attempt	__________
_____	Cancer	__________	_____	Broken bones	__________
_____	Gonorrhea	__________	_____	High blood pressure	__________
_____	Syphilis	__________	_____	Eczema	__________
_____	Bone disease	__________	_____	Hepatitis	__________
_____	Heart problems	__________			

When was your child's last physical examination? ______________________________
If your child has ever been hospitalized, what was it for?

____
____

FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any member of the immediate family has had. When you check an item, please note the member's relationship to the child.

	Condition	Relationship		Condition	Relationship
_____	Alcoholism	__________	_____	Schizophrenia	__________
_____	Drug Abuse	__________	_____	Suicide/attempt	__________
_____	Heart trouble	__________	_____	Other mental illness:	__________
_____	Diabetes	__________		______________________________	
_____	Cancer	__________		______________________________	
_____	Depression	__________		______________________________	

ABBEY NEUROPSYCHOLOGY CLINIC
366 S. California Avenue, Suite 14
Palo Alto, CA 94306
Ph: 650-614-0014
Fax: 650-204-6502

OTHER INFORMATION

If your child has experience any significant losses or traumas, please describe:

____
____
____
____

What are your child's favorite activities?

____
____
____
____

What activities would your child like to engage in more often than he/she does at present?

____
____
____
____

What disciplinary techniques do you usually use when your child behaves inappropriately?

Ignore problem behavior	Send child to his/her room
Scold child	Threaten child
Spank child	Reason with child
Redirect child's interest	Time out
Revoke privileges	Don't use any technique
Revoke food	Other:__________________

Which disciplinary techniques are usually effective?

____
____

With what type of disciplinary techniques are usually ineffective?

____
____

With what type of problem(s)?

____
____

What have you found to be the most satisfactory ways of helping your child?

____
____

What are your child's strengths?

____
____

ABBEY NEUROPSYCHOLOGY CLINIC
366 S. California Avenue, Suite 14
Palo Alto, CA 94306
Ph: 650-614-0014
Fax: 650-204-6502

Is there any other information that you think may help us in working with your child?

____
____
____
____
____
____

Please describe your goals.

____
____
____
____
____
____
____
____
____
____
____
____
____
____

Child's Name ____ **Date** ___________________

Parent's Name ____

Parent's Signature ____