NEUROPSYCHOLOGY BACKGROUND FORM

Children's of Alabama
Division of Pediatric Hematology, Oncology, and Blood & Marrow Transplantation
Phone: (205) 638-9285

Today's Date: _____

Person Completing this Form: _____ Relationship to Patient: _____

The questions below will help us support your teen or young adult. Each section will help determine the level of psychological and neuropsychological care he or she will need. This form will also help identify child life and school/ vocational needs. Please complete this form to the best of your knowledge. It will likely be helpful for you to complete this form with your teen/young adult.

DEMOGRAPHIC INFORMATION

1. Patient's Name: _____ Date of Birth: _____ Age: _____
2. Race/Ethnicity: _____
3. Parent/Caregiver Name: _____ Relationship to Patient:_____
4. Home phone#: _____ Cell#: _____ Best Time to Call: _____

❒ No ❒ Yes

Does the patient speak a language **other** than English?

If yes, what language(s)?_____

If yes, what is the language spoken **most** at home? _____

BIRTH AND DEVELOPMENTAL INFORMATION

1. Were any of the following complications experienced during pregnancy?

Complication	No	Yes	If Yes, Please Describe
Prescription Medications Needed			
Bleeding			
Toxemia			
High Blood Pressure			
Fever or Rashes			
Serious Injury			
Gestational Diabetes			
Infection or Illness			

2. Were any of the following used during the pregnancy?

Cigarettes ❒ cNo ❒ cYes _____ cigarettes per … ❒ c Da ❒ c Week

Alcohol ❒ cNo ❒ cYes _____ drinks per … ❒ c Da ❒ c Week ❒ c Month

Marijuana ❒ cNo ❒ cYes, please describe the type and frequency of use: _____

Drugs ❒ cNo ❒ cYes, please describe the type and frequency of use: _____

3. The patient was born: ❒ on time ❒ early ❒ late

4. How long was the pregnancy? _____ weeks What was the patient's birthweight?

5. Type of delivery: ❒ vaginal ❒ planned C-section ❒ emergency C-section

If there was an emergency C-section, please explain why: _____

_____

6. Did the patient experience complications in the first weeks of life (e.g., jaundice, ❒ No ❒ Yes

If yes, please describe: _____

7. Did the patient stay in the Neonatal Intensive Care Unit ❒ No ❒ Yes

If yes, what types of treatments or procedures did he/she need?

_____

8. Were there any concerns about the patient's early development? ❒ No ❒ Yes

If yes, please explain _____

_____

9. When did the patient achieve the following milestones? Please provide approximate ages.

Sat without support	_____	Spoke first words	_____	Toilet Trained	_____
Crawled	_____	Put 2-3 words together	_____		
Walked	_____	Spoke in sentences	_____		

10. Prior to being in the hospital, did the patient have problems with any of the following **motor skills**?

- ❒ Walking/running without tripping or falling
- ❒ Throwing, catching, or kicking balls
- ❒ Using stairs
- ❒ Using buttons and/or zippers
- ❒ Handwriting
- ❒ Using utensils (i.e., fork and knife)

11. Prior to being in the hospital, did the patient have any of the following **speech/language problems**?

- ❒ Speech was hard to understand
- ❒ Limited vocabulary Trouble thinking of the words he/she wanted to say
- ❒ Poor grammar

What **therapies** did the patient receive **BEFORE** diagnosis? ***(Please check all that apply)***:

Therapy	Location	Past	Current (at time of diagnosis)	Reason for therapy (e.g., balance, fine motor control, articulation)
Speech/Language Therapy	Early Intervention (EI)	❒ Yes	❒ Yes	
	School	❒ Yes	❒ Yes	
	Outpatient Clinic	❒ Yes	❒ Yes	
Occupational Therapy	Early Intervention (EI)	❒ Yes	❒ Yes	
	School	❒ Yes	❒ Yes	
	Outpatient Clinic	❒ Yes	❒ Yes	
Physical Therapy	Early Intervention (EI)	❒ Yes	❒ Yes	
	School	❒ Yes	❒ Yes	
	Outpatient Clinic	❒ Yes	❒ Yes	

1. What hand does the patient use most? ❒ Right ❒ Left ❒ Both, ambidextrous
2. Is there anyone in the family that is left-handed? ❒ No ❒ Yes – *Who?*_____
3. Has the patient been prescribed glasses or contacts? ❒ No ❒ Yes
4. Does the patient wear hearing aids? ❒ No ❒ Yes
5. Please list serious illnesses, hospitalizations, concussions, or surgeries that the patient had **BEFORE DIAGNOSIS**.

Age	**Please explain the event *(diagnosis, reason for hospitalization, etc.)***
____	_____
____	_____
____	_____
____	_____
____	_____

6. Please list any prescription medications or supplements the patient is **currently** taking.

Name of Medication	**Reason for Medication**	**Dose *(if known)***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

❒ Does the patient know the names of his/her medications? No Yes

8. Does the patient manage his/her own medication regimen

❒ (e.g., takes medications same time each day)? No Yes

9. When does the patient go to sleep on school nights? _____ On weekends? _____

10. When does the patient wake up on school mornings? _____On weekends? _____

❒ No Yes

11. Does the patient have any difficulty falling asleep or staying asleep?

If yes, please describe: _____

12. Please check all that apply regarding the patient's appetite:

- ❒ No problems with appetite
- ❒ Eats too little
- ❒ Eats too much
  - ❒ Has food allergies Picky eater
  - ❒ Recent large weight **loss**
  - ❒ Recent large weight **gain**
  - ❒ Other:_____

13. Does the patient have difficulty swallowing prescribed ❒ No ❒ Yes

14. Is this your family's first visit to a hospital? ❒ No ❒ Yes

15. Please place a check mark (√) in the box if the patient or any of his/her relatives have been diagnosed with the following medical/developmental or psychological conditions. (Please note: Relatives include the patient's biological parents, siblings, aunts, uncles, cousins, and grandparents.)

	PATIENT	**RELATIVE**
CONDITION	Age Identified	Relationship to Child
Autism Spectrum Disorder	_____	_____
Developmental Delays	_____	_____
Language/Speech Problem	_____	_____
Attention-Deficit/Hyperactivity Disorder (ADHD/ADD)	_____	_____
Learning Disability or Dyslexia	_____	_____
Intellectual Disability *(previously "mental retardation")*	_____	_____
Tics or Tourette's Syndrome	_____	_____
Depression	_____	_____
Anxiety	_____	_____

Bipolar Disorder	_____	_____
Schizophrenia	_____	_____
Epilepsy (Seizures)	_____	_____
Genetic Disorders (e.g., Down Syndrome)	_____	_____
Alcoholism	_____	_____
Drug Use and/or Dependence (including marijuana, heroin, cocaine, methamphetamine, etc.)	_____	_____
Other: _____	_____	_____

SCHOOL INFORMATION

1. Please indicate the patient's current education setting:

___ Public High School ___ Private High School ___ Home-Schooled
___ Technical/Trade School ___ College/University ___ Not Enrolled

2. *(If enrolled)* Name of School and Address: _____
_____

If homeschooled, please describe the nature of the homeschooling program (e.g., co-op, educational program used):
_____

3. *(If enrolled)* What grade is the patient in? _____

❒ No ❒ Yes
Has the patient ever been retained or held back a grade?

4. What grades does/did the patient typically earn? _____

5. What is the patient's weakest or most challenging subject? _____ Strongest subject? _____

6. Please place a check mark (√) on the line if the patient has struggled in any of the following areas:

___ Reading quickly or fluently	___ Math calculations	___ Organizing school materials
___ Reading comprehension	___ Using fractions	___ Keeping track of due dates
___ Learning vocabulary words	___ Using percentages	___ Turning in homework
___ Developing ideas for essays	___ Math word problems	___ Memorizing facts
___ Writing an organized essay	___ Using graphs with a key/ legend	___ Finishing tests within the time limit

7. Does the patient have an Educational Plan or Program? If yes, please indicate what type: ___IEP ___504 Plan

8. *(If enrolled)* Does the patient **currently** receive any support/intervention services at school? Please check all that apply:

___ Physical Therapy ___ Occupational Therapy ___ Speech/Language Therapy
___ Vision Impaired ___ Hearing Impaired ___ Adaptive PE
___ Tutoring ___ Pull-Out or Small Group Instruction ___ English as a Second Language
___ Individual Aide ___ Behavior Intervention Plan ___ Other: _____

10. Has the patient ever been suspended or expelled from school? ❒ No ❒ Yes

If yes, please explain:

11. Is the patient on track to graduate from high school OR has the patient graduated from high school? ❒ No ❒ Yes
12. Does the patient have a transition plan to prepare him/her for higher education or career and employment goals? ❒ No ❒ Yes
13. Please describe the patient's plans for after high school (e.g., technical school, college/university, employment).

_____

Please answer the following questions only if the patient is currently enrolled in an educational setting.

14. Is the school team aware of the patient's medical diagnosis? ❒ No ❒ Yes
15. Would you like help explaining the patient's diagnosis and associated needs to the school? ❒ No ❒ Yes
16. Do you understand the patient's educational rights? ❒ No ❒ Yes
17. Do you need help asking the school to provide additional educational services for the ❒ No ❒ Yes
18. Would you like help developing a plan for sharing information about the patient's school absences and medical diagnosis with his/her peers? ❒ No ❒ Yes

BEHAVIORAL, EMOTIONAL, AND SOCIAL FUNCTIONING

1. Has the patient ever been tested or evaluated by a psychologist or counselor due to behavioral, emotional, or social concerns? ❒ No ❒ Yes

   If yes, when did this occur (date)? _____ How old was the patient? _____
   What were the results and conclusions?

_____

2. Would you describe the patient as anxious or fearful? ❒ No ❒ Yes
3. Do you believe the patient worries more than other individuals his/her age? ❒ No ❒ Yes
4. Is the patient fearful of the hospital or medical procedures? ❒ No ❒ Yes
5. Does the patient have difficulty receiving shots (e.g., needs to be held down by nurse)? ❒ No ❒ Yes
6. Does the patient appear sad, down, or depressed? ❒ No ❒ Yes
7. Does the patient feel accepted by peers his/her age? ❒ No ❒ Yes

8. Is the patient good at making friends? ❒ No ❒ Yes

9. Does the patient have a close group of friends? ❒ No ❒ Yes

10. Does the patient socialize best with children who ❒ His/her own ❒ Younger ❒ Olde

11. Has the patient been bullied at school? ❒ No ❒ Yes

    If yes, when did this occur?

12. Has the patient engaged in rule-breaking behaviors (e.g., stealing, lying, cheating). ❒ No ❒ Yes

    If yes, please describe: _____

13. Is the patient involved in after school activities (e.g., clubs, sports, church groups)? ❒ No ❒ Yes

    If yes, please describe:

14. What are the patient's favorite activities during free time?_____

    _____

15. Do you believe the patient's level of independence is appropriate for his/her age? For example, is the patient able to independently complete daily tasks (e.g., cooking, cleaning, dressing)? If no, please describe any concerns you have about the patient's level of independence for his/her age: ❒ No ❒ Yes

    _____

16. Is the patient able to drive a car? ❒ No ❒ Yes

FAMILY INFORMATION AND FAMILY STRESSORS

1. Is the patient: Biological Adopted In Foster Care

2. Parent information:

	Birth Mother	**Birth Father**
Name	_____	_____
Highest Grade Completed	_____	_____
Occupation	_____	_____

3. Parents' Relationship: ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Never Married

   If divorced or separated, what was the patient's age at divorce or separation? _____

   How often does the other parent see the patient?

   ❒ Weekly or more often ❒ Once or twice per month ❒ Few times per year ❒ Never

   If divorced, has either parent re-married? _____

4. Please list the patient's **siblings**:

Name	Age	Sex	Full	Half	Step	Lives in the home?
1. _____	_____	____				___ No ___ Yes
2. _____	_____	____				___ No ___ Yes
3. _____	_____	____				___ No ___ Yes

5. Please list all **persons** living in the home:

Name	Relation to Child
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

6. Sometimes patients and families face a challenging medical diagnosis and other significant family stressors. When we understand family stressors impacting a patient's family, we can work to support both the patient and family to the best of our ability. If you are comfortable doing so, **please indicate if any of the following stressful or traumatic events have impacted your family in the past 12 months.**

- ❒ Parent changed job
- ❒ New baby at home
- ❒ Family financial problems (e.g., food or housing insecurity)
- ❒ Experienced a traumatic event
- ❒ Physical, emotional, or sexual abuse
- ❒ Neglect
- ❒ Problems with alcohol and/or drug use
- ❒ Other:
- ❒ Discrimination (racial, religious, sexual orientation, etc.)
- ❒ Family moved
- ❒ Trouble with the law (arrest, imprisonment)
- ❒ Department of Human Resources (DHR)/Child Protective Services (CPS) involvement
- ❒ Loss of a family member/close friend
- ❒ Caregiver separation or divorce
- ❒ Mental health problems (e.g., suicide attempt)

Please provide any additional information you are comfortable sharing with our team:

_____
_____
_____
_____

COPING AND RESILIENCE

1. What are the patient's strengths? _____
   _____

2. What is the most difficult or challenging experience the patient has faced? _____

   How did the patient cope with this experience? _____

   _____

3. Please describe religious, cultural, and/or personal values that are important for us to understand about your family:

   _____
   _
   _____
   _

❒ As a caregiver, do you have a strong social support system? No Yes
Who do you turn to for social support?

_____

5. How do you as a family cope with challenging medical appointments/procedures, bad news, or worries about the patient's diagnosis? _____

   _____

6. How comfortable do you feel communicating with the patient's medical team (e.g., oncologist, nurses) about the patient's diagnosis, treatments, and any concerns you may have?

❒ Very comfortable Somewhat comfortable Not comfortable

7. How comfortable do you feel sharing concerns with the patient's Hope and Cope team (e.g., psychologist, neuropsychologist, school liaison, child life, social work)?

❒ Very comfortable Somewhat comfortable Not comfortable

8. Have you been given information from the Hope and Cope team? ❒ No ❒ Yes

   If so, who provided you with the information? _____

Thank you for completing this form.

It will help us understand how to best help you and the patient.