Meyers Neuropsychological Questionnaire for Children

Delta Family Clinic South

Patient Name: _____

Age: _____ **Date of Birth**: _____ **Gender:** _____

1. Education: Highest Grade Completed: _____
Special Education: Yes OR No If Yes, What is the classification? _____

2. Where does the child attend school?

Name: _____ City, State: _____

College: _____ State: _____

3. Handedness: right OR left

Is the child employed? Yes OR No If **yes,** where? _____.

4. Is the child currently collecting disability benefits from the government? Yes OR No

5. Independence: Please choose an option below

☐ **Yes:** Persons who are living on their own or with others and assume the responsibilities of self-sufficiency are classified as independent.

Note: Children, who are living at home with their parents, are also classified as independent because they are as independent as society would expect them to be.

☐ **Partially Independent and Driving:** Once a person has lost the ability to supply one of their own basic needs (i.e. care for own finances or cooking meals, managing medications) then they are partially independent; but the individual is still allowed to drive.

☐ **Partially Independent and Not Driving:** Once a person has lost the ability to supply one of their own basic needs (i.e. care for own finances or cooking meals, managing medications) then they are partially independent; and the individual is also not allowed to drive.

☐ **Not Independent:** Has lost independence in two or more areas of function and is not allowed to drive

6. Who referred you to Delta Family Clinic? _____
Referral info**:** _____

7. What was the reason for the referral?: (Head injury, Memory Loss, Car Accident Etc.): _____
_____

8. What was the date of this incident or onset of illness? _____ OR N/A

9. Tell me about how the accident or illness occurred: _____
_____

10. Did the accident or illness cause the child to lose consciousness or alter their consciousness? ☐ Yes ☐ No

11. Please list any hospitalizations or medical treatment you sought for the child's current difficulties including medical studies, brain scans, etc.: _____
_____
_____

12. List any symptoms the child has been experiencing secondary to their current difficulties:
_____
_____

13. Please list all emotional symptoms: _____
_____

14. Please list all physical symptoms: _____
_____

15. Please list all thinking symptoms: _____
_____

Family Data

16. How would you describe the environment in which the child was raised? _____
_____
_____

17. Tell me about the child's history of relationships: _____
_____

Current Life Data

18. What is causing the most stress in the child's life? _____
_____

19. Does the child currently possess a valid driver's license? □ Yes □ No

20. Tell me about your family's medical history: _____
_____
_____

21. Does the child have, or has the child ever had, a history of mental health involvement (therapy or hospitalizations)?: _____
_____

22. What does the child do socially, or in leisure time for pleasure? _____
_____

23. Has there been any change in the child's eating or sleeping habits since their current difficulties began?:
_____

24. What have the child's emotional reactions been to their current difficulties?: _____
_____

25. Regarding, mental abilities, how has the child's memory, attention span, concentration, etc. been?:
_____

_____ _____
Patient/ Guardian signature Date

_____ _____
Therapist Signature Date