NELDC
New England Learning & Diagnostic Center

Child's full name: _____

Date of birth: _____ Age: _____ Grade: _____

Pronouns: ☐ he/him ☐ she/her ☐ they/them ☐ other: _____

Today's date: _____

Person completing form: _____

Relationship to child: _____

Best phone: _____ Email: _____

Primary caregiver(s):

Name: _____ Relationship: _____ Lives with child? ☐ Yes ☐ No

Name: _____ Relationship: _____ Lives with child? ☐ Yes ☐ No

Section 2: Reason for referral

1. What are your main concerns about your child's learning, behavior, or development?

2. When did you first notice these concerns?

3. What questions do you hope this neuropsychological evaluation will answer?

Section 3: Pregnancy and birth history

During pregnancy, were there any medical complications (e.g., high blood pressure, infections, substance use)?
☐ No ☐ Yes – please describe:

Length of pregnancy (weeks): _____

Type of delivery: ☐ Vaginal ☐ C-section (planned) ☐ C-section (emergency)

Birth weight: _____ lbs _____ oz

Any problems at birth (e.g., NICU stay, oxygen, jaundice, seizures)?
☐ No ☐ Yes – please describe and include length of hospital stay:

Section 4: Early developmental milestones

Approximate age your child:

Sat without support: _____ months

Crawled: _____ months

Walked independently: _____ months

Said first word (other than “mama/dada”): _____ months

Spoke in short phrases (2–3 words): _____ months

Toilet trained (daytime): _____ years

Toilet trained (nighttime): _____ years

Any concerns with early development (motor, language, social)?

☐ No ☐ Yes – please describe:

Did your child ever lose skills they previously had?

☐ No ☐ Yes – please describe:

Section 5: Medical and neurological history

Primary care provider: _____
Specialists (neurology, psychiatry, etc.): _____

Check any that apply (past or present) and explain below:

☐ Seizures

☐ Significant head injury / concussion

☐ Loss of consciousness

☐ Frequent ear infections / tubes

☐ Vision or hearing problems

☐ Chronic medical condition (e.g., asthma, diabetes)

☐ Genetic or neurological diagnosis

☐ Sleep problems (e.g., snoring, insomnia, frequent waking)

☐ Motor coordination problems

Details (include dates, hospitalizations, surgeries, test results if known – MRI, EEG, etc.):

Current medications (include dosage and reason):

Allergies (medications, foods, environmental):

Section 6: Developmental / therapy services

Has your child received any of the following? (check all that apply)

☐ Early Intervention (0–3)

☐ Speech-language therapy

☐ Occupational therapy

☐ Physical therapy

☐ ABA or autism services

☐ Counseling/psychotherapy

☐ Other (describe): _____

Age(s) and frequency of services:

Section 7: Educational history

Current school: _____ District: _____
Type: ☐ Public ☐ Private ☐ Charter ☐ Homeschool ☐ Other: _____

Has your child ever repeated a grade? ☐ No ☐ Yes – which grade? _____

Typical grades: ☐ Above average ☐ Average ☐ Below average

Does your child have any of the following?

☐ IEP (special education) Category(ies): _____

☐ 504 Plan Accommodations: _____

☐ Informal supports (tutoring, reading group, RTI, Title I, etc.)

Areas of strength at school (subjects, skills):

Areas of difficulty (check all that apply):

☐ Reading accuracy

☐ Reading fluency

☐ Reading comprehension

☐ Spelling / written expression

☐ Handwriting / fine motor

☐ Math calculation

☐ Math word problems

☐ Organization / planning

☐ Completing work on time

☐ Test-taking / performance anxiety

☐ Following directions

Previous testing (school or private):

Type of evaluation(s) and date(s): _____

Main findings or diagnoses (if known): _____

Section 8: Behavioral, emotional, and social functioning

Please check any current or past concerns and describe:

Attention / activity level:

☐ Easily distracted

☐ Difficulty sustaining attention

☐ Often “on the go” / very active

☐ Impulsive or acts without thinking

Executive skills:

☐ Disorganized materials

☐ Loses or forgets things often

☐ Trouble starting tasks

☐ Trouble finishing tasks

☐ Difficulty with transitions or changes in routine

Mood / behavior:

☐ Frequent sadness or low mood

☐ Irritability or anger outbursts

☐ Anxiety or excessive worry

☐ Obsessions or compulsive behaviors

☐ Tics or repetitive movements/sounds

☐ Self-harm or suicidal thoughts (past or present)

Social functioning:

☐ Difficulty making or keeping friends

☐ Prefers to be alone most of the time

☐ Trouble understanding social cues (tone of voice, facial expressions)

☐ History of bullying (victim or aggressor)

Describe any checked items (onset, frequency, severity, what helps):

Has your child received counseling or psychiatric treatment?

☐ No ☐ Yes – provider(s), dates, and helpfulness:

Section 9: Family and psychosocial history

Household members (names, ages, and relationship to child):

Major family stressors (past or current), such as moves, separations, deaths, financial stress, legal issues:

Family history (biological relatives) of any of the following? Check all that apply:

☐ Learning disability

☐ ADHD

☐ Autism spectrum

☐ Intellectual disability

☐ Speech/language disorder

☐ Anxiety

☐ Depression or bipolar disorder

☐ Substance use disorder

☐ Neurological condition (e.g., epilepsy, Tourette, dementia)

If yes, please explain who and what diagnosis (if known):

Primary language(s) spoken at home: _____

Cultural or religious factors you would like considered in this evaluation:

Section 10: Child strengths and interests

What are your child's strengths (personality, talents, skills)?

What activities does your child enjoy (hobbies, sports, interests, special interests)?

What motivates your child or works best as rewards?

Section 11: Safety and risk

Any current safety concerns (self-harm, aggression, running away, risky behavior)?
☐ No ☐ Yes – please describe:

Has your child ever been hospitalized for psychiatric or behavioral reasons?
☐ No ☐ Yes – dates and reasons:

Section 12: Additional information

Is there anything else you would like the clinician to know about your child or family?