



School aged

Child

Neurobehavioral History Questionnaire ©

CHILD'S FIRST NAME (MI) _____

LAST NAME _____

TODAY: _____
 Year Month Day

BIRTH: _____
 Year Month Day

AGE: _____
 Years Months Days

CHILD'S ADDRESS

Street _____

City _____

ST/Prov _____ Zip _____

CONTACT / LEGALLY RESPONSIBLE PERSON

Name _____

Relationship _____

Address _____

Phone _____

If parents are not together, custody is:

Joint Sole:

GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		HAND USED FOR WRITING <input type="checkbox"/> Left <input type="checkbox"/> Right	
HEIGHT _____		WEIGHT _____	
RACE OR ETHNICITY _____		RELIGION _____	
LANGUAGES SPOKEN _____		<input type="checkbox"/> English is 2 nd language	
EDUCATION			
Grade _____			
Special program _____			
School name _____			
District _____			
<input type="checkbox"/> Public		<input type="checkbox"/> Private	
		<input type="checkbox"/> Parochial	
<input type="checkbox"/> Home schooled			

LIVING ARRANGEMENT

- With both parents
- With one parent
- Alternates between parents
- Lives with other family, not parents
- Adoptive home
- Foster home
- Institutional residence
- Other arrangement

ADAPTIVE AIDS

- Eyeglasses for...*
- Reading or close work (far-sighted)
 - Distance (near-sighted)
- Hearing device for...*
- Left ear Right ear
- Ambulation aid...*
- Cane Walker Wheelchair

CHILD REFERRED BY

- Physician
- Insurance company
- Family
- Lawyer
- Court
- Other:

What is the reason for referral?

Name of referring person or agency

Address

Phone

PRIMARY PHYSICIAN

- Same as referral
- None

Name of Physician

Address

Phone

When was the last physical exam?

PRESENT CONCERNS

Describe present concerns about the child's...

LEARNING OR COGNITIVE ABILITIES

(Reading, Language, Math, Writing, etc.)

No concerns

BEHAVIORAL OR EMOTIONAL FUNCTIONING

No concerns

INJURY OR ILLNESS

Describe any injury or illness relevant to this evaluation

None relevant

When did the injury or illness occur?

What happened?

There is litigation related to this injury or illness

Describe the purpose of the litigation:

Any prior litigation related to this? No Yes (see below):

Malpractice suit Civil proceeding Criminal case

Other: _____

DIAGNOSES

None

Skip this section

Diagnosis	When diagnosed?	Treating Doctor or Clinic
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

MEDICATIONS

Medication Name

Prescription, over-the-counter, herbal, etc.

Condition used for

Dose

Times per day

Date Started

Side Effects

1.	2.	3.	4.	5.	6.	7.	8.	9.	10.

Use additional sheet for more medications

Child discontinued the following drugs in past month: _____

Had recent drug withdrawal reaction: _____



None

Drug	Reaction
1.	
2.	
3.	

Use additional sheet for more drug allergies

NEUROBEHAVIORAL REVIEW OF SYSTEMS

Check any current or prior problems. Include the approximate age or date of diagnosis.

NEUROLOGIC

- Aphasia
- Brain development disorder
- Brain Injury or Concussion
- Cerebral aneurysm
- Cerebral palsy
- Coma or loss of consciousness
- Epilepsy or Seizure
- Head size abnormality
- Infection of brain
- Mental retardation
- Neural tube defect (e.g., spina bifida)
- Neurological "soft signs"
- Neuromuscular disease or Movement disorder
- Spinal cord injury
- Stroke (CVA, cerebral hemorrhage)
- Tumor of brain or spinal cord

CARDIO-VASCULAR

- Blood disease
- Heart disease or disorder
- Hypoxia (lack of oxygen)

GASTRO-INTESTINAL

- Colon disease
- Liver disease
- Malnutrition or Dehydration
- Stomach or digestive disease

GENITAL-URINARY

- Bedwetting (enuresis)
- Bowel movement soiling (encopresis)
- Sexual organ abnormality Reproductive disorder
- Kidney disorder

MUSCULAR-SKELETAL

- Amputation
- Arthritis
- Atrophy of limb
- Fracture (current or recent)
- Muscle control disorder: tic twitching tremor
- Muscle weakness
- Paralysis
- Polio
- Skeletal abnormality

RESPIRATORY (LUNG)

- Asthma
- Other:

GENETIC/CHROMOSOMAL

Genetic/Chromosomal disorder (specify):

METABOLIC

Metabolic disorder (specify):

DERMATOLOGY

- Skin (rash, discoloration) or hair condition (describe):

CANCER In remission

Type & site of cancer(s): _____

Treatments for cancer: Chemotherapy Radiation Surgery

COMMON CHILD ILLNESS: Measles Mumps Chicken pox

OTHER PROBLEMS not listed above: _____

When
diagnosed?

HEAD, EARS, EYES, NOSE, THROAT

- Abnormality of head, ears, eyes, nose or throat
- Ear infections About how many? _____ Ages: _____
Treatments: _____
- Loss of hearing
- Visual disorder (specify):
- Eye movement or alignment disorder
- Nose disorder
- Swallowing disorder

ENDOCRINE

- Adrenal gland disorder
- Diabetes: Insulin-dependent Non-insulin dependent
- Hypoglycemia
- Pancreatic disorder
- Parathyroid disorder
- Pineal gland disorder
- Pituitary disorder
- Thyroid disorder

INFECTION

- Autoimmune disease
- AIDS HIV+
- Lyme disease
- Parasitic infection
- Recent infection
- Sexually transmitted disease

SLEEP DISORDER

- Insomnia
- Narcolepsy or sleep attacks
- Nighttime breathing difficulty

MENTAL HEALTH

- Anxiety disorder
- Attention Deficit Hyperactivity Disorder
- Autism, Asperger's or Pervasive Developmental Disorder
- Bipolar disorder
- Conduct disorder
- Depression
- Obsessive-compulsive disorder
- Phobia
- Posttraumatic Stress Disorder
- Schizophrenia
- Tourettes

OTHER

- Allergies
- Birth or congenital defect
- Birth injury
- Dietary restrictions
- Eating disorder
- Fetal alcohol syndrome
- Nutritional problems
- Physically abused or history of physical neglect
- Toxic substance poisoning

When
diagnosed?

SEIZURES & EPILEPSY

Complete this section if a seizure has occurred or if the child has been diagnosed with epilepsy

None

Skip this section

Type of epilepsy (Grand Mal, Absence, Partial, etc.):

Seizures began after: Injury Illness Unknown

Age at first seizure:

When did the last seizure occur?

Has there been a prolonged loss of consciousness from a seizure? No Yes

Approximate number of lifetime seizures = less than 5 5-10 11-50 over 50

Approximate number of seizures per month:

Family history of seizures? No Yes Who:

History of fever (febrile) convulsion? No Yes

Describe the physical signs of a seizure:

Describe the behavioral signs of a seizure:

How many anti-epileptic medications have been tried?

SERIOUS INJURIES

Complete this section for any injury to the child serious enough to require medical attention

None

Skip this section

Date of injury	Description of injury
1	
2	
3	
4	
5	

Had a concussion or severe injury to the head How many concussions? _____

Had a period of unconsciousness associated with an injury to the head

How long a period of unconsciousness? _____

HOSPITALIZATIONS

List major hospitalizations

None

Skip this section

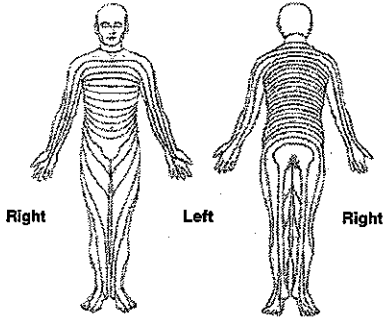
Date and Hospital	Description of problem and treatment
1	
2	
3	
4	
5	

PAINFUL CONDITIONS

There is a chronic pain condition (If not then skip this section). If there is a painful condition, ask the child to help complete this information.

Fill in painful areas

Place X on trigger point or very painful areas



List Painful Areas	Child's Pain Rating	Child's Pain Rating				
		None	Mild	Moderate	Severe	
1	Resting:	0	1	2 3 4	5	
	Moving:	0	1	2 3 4	5	
2	Resting:	0	1	2 3 4	5	
	Moving:	0	1	2 3 4	5	
3	Resting:	0	1	2 3 4	5	
	Moving:	0	1	2 3 4	5	
4	Resting:	0	1	2 3 4	5	
	Moving:	0	1	2 3 4	5	

Mild = Hurts a little.

Moderate = Hurts often but not always. Affects some activities.

Severe = Hurts all the time. Affects most activities.

What has been tried to control pain? Nothing has been tried

Medications Physical therapy Surgery Nerve block injections Chiropractic Psychological techniques

Other: _____

Headache

Child has a headache disorder
Complete this section

None out of the ordinary
Skip this section

If a specific type of headache has been diagnosed, what is it: _____

Age or date headaches began: _____

Headaches began after: Injury Illness Unknown cause

Location of headache (front, back, right side, left side, moves around, etc.) _____

How often do headaches occur? _____

How long do headaches usually last? _____

Over time headaches are: Improving Worsening Stable - not improving or worsening

What appears to start a headache? _____

What other physical problems occur with headaches? _____

What improves headaches? _____

What worsens headaches? _____

Migraine screener:

	NO	YES
Has a headache limited the child's activities for a day or more in the last three months?	<input type="checkbox"/>	<input type="checkbox"/>
Does the child get nauseous or sick to his/her stomach when a headache occurs?	<input type="checkbox"/>	<input type="checkbox"/>
Does light or noise bother the child when there is a headache?	<input type="checkbox"/>	<input type="checkbox"/>

TESTS & EVALUATIONS IN THE PAST YEAR

Professional Consultations

<input type="checkbox"/> Family physician or Pediatrician	_____
<input type="checkbox"/> Neurology	_____
<input type="checkbox"/> Psychiatry	_____
<input type="checkbox"/> Psychology	_____
<input type="checkbox"/> Neuropsychology	_____
<input type="checkbox"/> Speech & Language	_____
<input type="checkbox"/> Audiology (Hearing)	_____
<input type="checkbox"/> Physiatry (Physical medicine)	_____
<input type="checkbox"/> Ophthalmology or Optometry (Visual)	_____
<input type="checkbox"/> Cardiology (Heart)	_____
<input type="checkbox"/> Pulmonary (Lungs)	_____
<input type="checkbox"/> Endocrinology	_____
<input type="checkbox"/> Dermatology	_____
<input type="checkbox"/> Infectious disease	_____
<input type="checkbox"/> Surgery	_____
<input type="checkbox"/> Other:	_____

Date

Diagnostic Tests

<input type="checkbox"/> X-ray	_____
<input type="checkbox"/> CT scan	_____
<input type="checkbox"/> MRI	_____
<input type="checkbox"/> Electroencephalogram (EEG)	_____
<input type="checkbox"/> Blood work	_____
<input type="checkbox"/> Genetic testing	_____
<input type="checkbox"/> Ultrasound	_____
<input type="checkbox"/> Lead level	_____
<input type="checkbox"/> Biopsy	_____
<input type="checkbox"/> Electrocardiogram (ECG or EKG)	_____
<input type="checkbox"/> Electromyogram (EMG)	_____
<input type="checkbox"/> MRA	_____
<input type="checkbox"/> PET	_____
<input type="checkbox"/> fMRI	_____
<input type="checkbox"/> SPECT	_____
<input type="checkbox"/> Other:	_____

Date

MENTAL HEALTH HISTORY

None

Which professionals did the child see at each treatment?

Date(s)	Psychiatrist	Psychologist	Other Mental Health (Social Worker, Counselor)	Program or Hospitalization	Reason for treatment
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

REHABILITATION HISTORY

None

Which professionals did the child see at each treatment?

Date(s)	Physical Therapy	Occupational Therapy	Speech / Language Therapy	Program or Hospitalization	Reason for treatment
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

SUBSTANCE USE

Alcohol

Never used alcohol
Skip this section

The child drinks alcohol Suspect drinking but not sure Used alcohol but has stopped

If the child drinks, describe the usual drinking pattern:

At what age did the child begin drinking alcohol?

The child has gotten into trouble when drinking:

Accident(s) Family conflicts Fights Legal problems School suspension

There is a family history of heavy drinking or alcoholism

Child has been in an alcohol treatment program

Recreational Drugs

Marijuana, cocaine, hallucinogenics, uppers, downers, etc.

Never used drugs
Skip this section

The child has used illegal drugs Suspected drug use but not sure Used drugs but has stopped

At what age did the child begin using illegal drugs?

Type of drugs used:

How often are drugs used?

The child...

has gone through drug withdrawal had drug overdose is dependent on or abused a prescription drug

There is a family history of drug use or addiction

Child has been in a drug treatment program

Other Substances

Tobacco

None

Cigarettes Cigars Pipe Chewing tobacco

How much does the child smoke per day?

At what age did the child start smoking?

Used to smoke but stopped *When stopped?*

About how many per day?

Caffeine

None

Caffeinated soda _____

Coffee _____

Tea _____

Toxic Exposure

Child has been harmed by a toxic substance (lead, pesticide, radiation, chemical)

Explain:

EARLY HISTORY

When the child was born how old was...

Mother _____

Father _____

Mother was unknown

Father was unknown

Mother's Health when Pregnant with this Child

Prenatal Care

- Good – Visited doctor as requested
 Poor – Few or no doctor visits

Pregnancy Problems

- Illness related to pregnancy
(Toxemia, Pre-eclampsia, Diabetes, Rh incompatibility, etc.)
 Illness unrelated to pregnancy
 Nutritional problems
 Psychological problems or stress
 Involved in accident while pregnant
 Other health problem while pregnant:

Medications

mother used just before or during pregnancy

Prescribed & Over-The-Counter

- 1 _____
2 _____
3 _____
4 _____
5 _____

Substances

mother exposed to while pregnant

- Alcohol
 Cigarette smoking by mother
 Second hand smoke
 Recreational drugs (pot, cocaine, etc.)
 Toxic substance exposure

Birth of Child

Birth:

- On time (39-41 weeks)
 Prematurely: _____
 After due date: _____

Method:

- Normal delivery
 Forceps-assisted
 Vacuum/suction-assisted birth

Delivery:

- Vaginal
 Planned C-section
 Emergency C-section

Physical:

Weight: _____

Length: _____

Apgars:

1st _____ 2nd _____

Where there problems when the child was born or shortly thereafter?

No Yes: _____

Was in fetal distress (respiratory or heart rate problem)

Prolonged labor

Position:

- Transverse (crosswise)
 Posterior first
 Breech

Illness:

- Hydrocephalus
 Bleed into brain
 Infection
 Aspiration
 Small for birth age
 Lung disorder
 Seizure
 Jaundice
 Small head
 Large head
 Oxygen deprivation
 Failure to thrive

Hospital:

How long was the child in the hospital? _____

Placed in intensive care? No Yes

Special medical equipment used? No Yes

Surgery required? No Yes

DEVELOPMENT

Rate the child (to age 3).

Gross Motor Skills

Sitting up, walking independently

EARLY

AVERAGE

LATE

Describe any problems:

Fine Motor skills

Using utensils, drawing, scissors, tying shoelaces

EARLY

AVERAGE

LATE

Describe any problems:

Language

Talking in 2-3 word sentences

EARLY

AVERAGE

LATE

Describe any problems:

Describe any early therapeutic services provided to the child None provided

Physical Therapy

Ages or years provided _____

Where provided?

Reason for therapy:

Occupational Therapy

Ages or years provided _____

Where provided?

Reason for therapy:

Speech Therapy

Ages or years provided _____

Where provided?

Reason for therapy:

Toilet trained at age: _____

Temperament

Describe the child's early temperament

Check a circle in each area

	EASY CHILD	AVERAGE	DIFFICULT CHILD
Activity Level Child's usual activity level	Low <input type="radio"/>	<input type="radio"/>	High <input type="radio"/>
Distractibility Concentration and attention when child is not particularly interested	Low <input type="radio"/>	<input type="radio"/>	High <input type="radio"/>
Intensity How intensely child tends to react, whether positively or negatively	Low <input type="radio"/>	<input type="radio"/>	High <input type="radio"/>
Regularity How predictable child ate and slept	Regular <input type="radio"/>	<input type="radio"/>	Irregular <input type="radio"/>
Sensory Threshold How sensitive the child was to touch, taste, smell, sound, light	High <input type="radio"/>	<input type="radio"/>	Low <input type="radio"/>
Approach/Withdrawal How the child reacted to a new situation or to strangers	Approach <input type="radio"/>	<input type="radio"/>	Withdrawal <input type="radio"/>
Adaptability How easily the child adapted to transitions in activities and situations	Good <input type="radio"/>	<input type="radio"/>	Poor <input type="radio"/>
Persistence Stubbornness, resistance to giving up	Low <input type="radio"/>	<input type="radio"/>	High <input type="radio"/>
Mood Whether child tended to emotionally react in a positive or negative way	Positive <input type="radio"/>	<input type="radio"/>	Negative <input type="radio"/>

Parenting Style

List the methods used to influence the child's behavior (e.g., talking to child, time out, loss of privileges, rewards, punishment, etc.) and method effectiveness.

Technique	% of time method used	METHOD EFFECTIVENESS		
		Excellent	Good	Poor
1.		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

EDUCATION

	Grades Received (A...B...C...or 90...80...etc.)	Academic Strengths (Best Subjects, Areas of Enjoyment)	Academic Weaknesses (Weakest Subjects, Dyslexia, Inattention)	
Elementary School				
Middle School / Jr. High				
Vocational				Standardized Testing Scores
High School				
College				GRE or other

Special classes or academic services have been provided (check all that apply):
 Resource Room Special Education Emotional or Behavioral Support Tutoring Other:

Behavioral or social problems in school Describe:

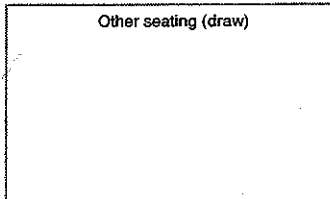
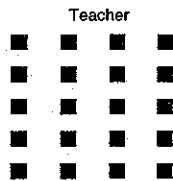
Dropped out of school Explain:

Learning style: Verbal, asked lots of questions Hands-on, visual, non-verbal Unknown

DAILY SEATING ARRANGEMENT

Circle the approximate location where the child is seated.

If there is more than one class indicate the seat for each class.



Frequent seating changes

Class size(s) range from _____ to _____

BASIC SKILLS

	Well Above Average	Age or Grade Appropriate	Below Average	Well Below Average
Reading Words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Listening Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Written Expression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Art, Visual-motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GRADE TRANSITIONS

- Child has repeated a grade
 Child skipped a grade

CURRENT GRADES

Subjects (list below)	Well Above Average A, 90, S+	Above Average B, 80-89, S	Average C, 70-79, S-	Below Average D-F, 60's, U/NI
1:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SPECIAL SERVICES RECEIVING NOW

- Resource room
 Special education
 Learning support
 Emotional/behavioral support
 Tutoring
 Other:

ADVANCED SERVICES RECEIVING NOW

- Advanced class instruction or placement in:

TEACHERS CONCERNS

Academic Performance

Behavior

FAMILY HISTORY

Describe the child's
Parents

MOTHER Age _____ <input type="checkbox"/> Deceased		FATHER Age _____ <input type="checkbox"/> Deceased	
Child raised by: <input type="checkbox"/> Biological mother <input type="checkbox"/> Adoptive <input type="checkbox"/> Stepmother <input type="checkbox"/> Foster <input type="checkbox"/> Other:		Child raised by: <input type="checkbox"/> Biological father <input type="checkbox"/> Adoptive <input type="checkbox"/> Stepfather <input type="checkbox"/> Foster <input type="checkbox"/> Other:	
Education	Occupation	Education	Occupation
Health Problems		Health Problems	
Languages Spoken		Languages Spoken	

Describe the child's
Brothers & Sisters

For a deceased sibling,
write the age of death
and "D" after the age

No siblings

Age	Gender	Education	Occupation	Medical, Behavioral or Academic Problems

Family Medical History Check all conditions that occurred in the child's biological family

Biological family history is unknown

	Mother	Mother's Mother	Mother's Father	Father	Father's Mother	Father's Father	Childs Sibling(s)
NEUROLOGIC							
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Movement disorder (Parkinson's, tremor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuromuscular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other neurologic:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MENTAL HEALTH							
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety or Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Illness (Manic-Depression)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive-Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ACADEMIC							
Attention Deficit Hyperactivity Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading Disability (Dyslexia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER							
Genetic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left-handedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other significant family disorder not listed above							
Describe:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe any major or unusual medical conditions in the patient's biological aunts, uncles or 1st cousins: