Pediatric History Questionnaire
Developmental-Behavioral Pediatrics Clinic
Children’s Medical Center Dallas

Please print and fill out this form as completely as possible. Fax the completed form to (214) 456-5702, attention to DBP Clinic. If you have any questions, please call (214) 456-5558.

Patient Name: ___________________________  Patient DOB: ______________________

Dear Parent/Guardian:

This questionnaire will provide us with important information regarding your child’s birth, early medical history, education, and medical issues surrounding their medical condition, which will allow us to work with you more effectively. By completing this questionnaire prior to your appointment, you will be helping us to better understand your questions and the concerns which are affecting your child and your family. Based on the age of your child some of the questions/information requested may not be appropriate. Please answer these questions as completely as possible. Thank you for your time.

Today’s Date: ___________________________

* Patient’s Gender: □ Male  □ Female

Mother’s Name: ___________________________  Father’s Name: ___________________________

Stepmother’s Name: _______________________  Stepfather’s Name: _______________________

Guardian’s Name (if different than above)

________________________________________________________

Home Address: ____________________________________________

________________________________________________________

City State Zip County

Telephone Numbers:

Mother’s Home #: ___________________________  Father’s Home #: ___________________________

Mother’s Cell #: ___________________________  Father’s Cell #: ___________________________

Mother’s Work #: ___________________________  Father’s Work #: ___________________________
Name of Person Completing this form ____________________________________________

Relationship to Child (parent, guardian, foster-parent etc.) _____________________________________

Child’s Pediatrician: _____________________________________Phone#: ________________________

Address: ______________________________________________________________________________

Please list the name, specialty, hospital or program affiliation, and address of any other physicians currently providing medical care to your child.

<table>
<thead>
<tr>
<th>Physician’s Name</th>
<th>Specialty</th>
<th>Hospital/Program Affiliation</th>
<th>Address (if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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</tbody>
</table>

**Cultural History:**

Which of the following best describes your child? (place a check mark)

<table>
<thead>
<tr>
<th>White, not of Hispanic origin</th>
<th>African-American or Black, not of Hispanic origin</th>
<th>Hispanic</th>
<th>Native American Indian or Alaskan Native</th>
<th>Asian, Asian-American, or Pacific Islander</th>
<th>Other</th>
</tr>
</thead>
</table>

Which of the following best describes the child’s father? (place a check mark)

<table>
<thead>
<tr>
<th>White, not of Hispanic origin</th>
<th>African-American or Black, not of Hispanic origin</th>
<th>Hispanic</th>
<th>Native American Indian or Alaskan Native</th>
<th>Asian, Asian-American, or Pacific Islander</th>
<th>Other</th>
</tr>
</thead>
</table>

Which of the following best describes the child’s mother? (place a check mark)

<table>
<thead>
<tr>
<th>White, not of Hispanic origin</th>
<th>African-American or Black, not of Hispanic origin</th>
<th>Hispanic</th>
<th>Native American Indian or Alaskan Native</th>
<th>Asian, Asian-American, or Pacific Islander</th>
<th>Other</th>
</tr>
</thead>
</table>
Predominant language spoken in your home:  

<p>| |</p>
<table>
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<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
</tr>
<tr>
<td>Spanish</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

What is your child’s best language, what language does your child feel most comfortable speaking in?  

<p>| |</p>
<table>
<thead>
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</thead>
<tbody>
<tr>
<td>English</td>
</tr>
<tr>
<td>Spanish</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

Are there other languages spoken in the home?  

☐ No  ☐ Yes  

If yes please list: __________________________________________________

Referral History (Please be SPECIFIC):

1. Who referred your child to this clinic? ____________________________________________

2. Why were you referred to this clinic? ____________________________________________

3. Describe the problems that are affecting your child and your family. ________________

4. When did you first become aware of these problems? ________________________________

5. What seems to help the problems? _______________________________________________

6. What seems to make the problems worse? _________________________________________

7. Have these problems changed since you first noticed them? If yes, how? ______________

8. Has your child received an evaluation or treatment for these problems before?  
   ☐ yes  ☐ no  
   A. If yes, when and with whom? Please provide a copy of any prior evaluations including any school evaluations (MET’s or IEP’s)

9. Do you or the school have any concerns about your child’s behavior?  
   ☐ yes  ☐ no  
   If yes, please explain. (i.e., What are the concerns, when did these concerns begin.)

10. What do you hope to learn or gain from this visit? _________________________________

Page 3 of 13
11. In what way are you hoping that we can be helpful with these problems? ________________________________________________________________

_________________________________________________________________________________________________________________________________

12. Please list your child’s strengths: ____________________________________________________________

_________________________________________________________________________________________________________________________________

**Family History:**

**Mother’s Name:** ____________________________  **Age:** ____________________________

Highest level of education completed:

<table>
<thead>
<tr>
<th>Grade School (grades 1-8)</th>
<th>Some College</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School, but didn’t graduate</td>
<td>College Graduate</td>
</tr>
<tr>
<td>High School, Completed</td>
<td>Post Graduate Level</td>
</tr>
<tr>
<td>Training after High School, other than college</td>
<td></td>
</tr>
</tbody>
</table>

Occupation: ____________________________________________________________
Place of Employment: __________________________________________________

**Father’s Name:** ____________________________  **Age:** ____________________________

Highest level of education completed:

<table>
<thead>
<tr>
<th>Grade School (grades 1-8)</th>
<th>Some College</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School, but didn’t graduate</td>
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<tr>
<td>Training after High School, other than college</td>
<td></td>
</tr>
</tbody>
</table>

Occupation: ____________________________________________________________
Place of Employment: __________________________________________________

**Step-parent’s name (if applicable):** ____________________________  **Age:** ____________________________

Highest level of education completed:

<table>
<thead>
<tr>
<th>Grade School (grades 1-8)</th>
<th>Some College</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School, but didn’t graduate</td>
<td>College Graduate</td>
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<td>High School, Completed</td>
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</tr>
<tr>
<td>Training after High School, other than college</td>
<td></td>
</tr>
</tbody>
</table>

Occupation: ____________________________________________________________
Place of Employment: __________________________________________________

Parents are:

- **Married** □ yes □ no  **Date:** ____________________________
- **Separated** □ yes □ no  **Date:** ____________________________
- **Divorced** □ yes □ no **Date:** ____________________________
- **Unmarried** □ yes □ no  **Date:** ____________________________
- **Widowed** □ yes □ no  **Date:** ____________________________
Family History (continued):

• If parents are divorced, who has legal custody?  
  Mother  
  Father  
  Joint  
  Other  
  If other, please specify: __________________________________________________________________________

• If parents are separated or divorced is there any disagreement regarding whether the child should receive clinical services through our department?  
  □ yes  
  □ no

• If parents are separated or divorced is there a court ordered parenting plan or divorce decree that outlines parental rights related to the child’s medical care?  
  □ yes  
  □ no

• Are you hoping to use this evaluation in any legal proceedings?  
  □ yes  
  □ no

  **Please provide documentation regarding custody, we may not be able to evaluate your child unless this has been received.**

• If parents are divorced or separated, how often does the child visit the parent that he or she does not live with?

____________________________________________________________________________________________
____________________________________________________________________________________________

• Is this child a foster child?  
  □ yes  
  □ no

• Is this child adopted?  
  □ yes  
  □ no
  If yes, please give as much information regarding biological parent(s) as you can: ________________________________________________________________

____________________________________________________________________________________________
____________________________________________________________________________________________

• If a foster child or adopted child, how long has the child been in your home? __________

• If a foster child or adopted child, is this child aware that they are a foster child or adopted?  
  □ yes  
  □ no

Who is living in the home at this time? (Please include everyone).

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship to Child</th>
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</tbody>
</table>

Family members living outside of the home. (For example, a biological parent, brothers or sisters).

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship to Child</th>
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</tbody>
</table>

• How many times has the child moved during the past 3 years? ________________________________
Family History (continued):

During the past 12 months, has your family experienced any of the following situations:

- Death of a family member
- Serious Illness
- Unemployment
- Marital Problems
- Psychiatric Problems
- Alcohol/Drug Problems
- Legal Problems

<table>
<thead>
<tr>
<th>Situation</th>
<th>Yes</th>
<th>No</th>
<th>Who (relationship to child)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death of a family member</td>
<td></td>
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<tr>
<td>Serious Illness</td>
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<tr>
<td>Unemployment</td>
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<td></td>
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<tr>
<td>Marital Problems</td>
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<td>Psychiatric Problems</td>
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<tr>
<td>Legal Problems</td>
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</table>

Has anyone in your family experienced the following:

- Speech or language problems
- Held back in school
- Mental retardation
- ADHD (Attention Deficit Hyperactivity Disorder)
- Autism
- Learning Disabilities
- Genetic disorder
- Suicide or attempted suicide
- Depression
- Anxiety
- Diagnosed with Manic-Depression
- Seizures (“fits”)
- Neurological disease/disorder
- Other health problems

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Which Family Member?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech or language problems</td>
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<tr>
<td>Held back in school</td>
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<tr>
<td>Mental retardation</td>
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<tr>
<td>ADHD</td>
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<td></td>
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<tr>
<td>Autism</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Genetic disorder</td>
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<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
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</tr>
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<td>Diagnosed with Manic-Depression</td>
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<td>Seizures (“fits”)</td>
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</tr>
<tr>
<td>Neurological disease/disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other health problems</td>
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<td></td>
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</tbody>
</table>

Please list anyone in the family who is left-handed or ambidextrous (mixed-handed):

1. ______________________  3. ______________________
2. ______________________  4. ______________________

Medical History:

A. Pregnancy and Delivery – this section is to be completed by the child’s mother if possible.

- Length of pregnancy (how many weeks/months?)
- Did you attend regular prenatal care? □ yes □ no
- Mother’s age when child was born
- Child’s birth weight
- Delivery was by: □ vaginal birth □ C-section
- Were forceps used? □ yes □ no
- Was delivery difficult? □ yes □ no
- Was it a breech birth? □ yes □ no
Medical History (continued):
Length of labor _______________________________________________________________
Problems with delivery □ yes □ no
(If yes, please describe; e.g., emergency cesarean section, slow heart rate, fever, cord around neck, etc.)
____________________________________________________________________________
____________________________________________________________________________
What were the Apgar scores @ 1 minute_______ 5 minutes _______10 minutes __________

B. Biological Mother’s Health During Pregnancy
Did the child’s mother experience any of the following during pregnancy?
Bleeding □ yes □ no
Gained 30 or more pounds □ yes □ no
Had toxemia or high blood pressure □ yes □ no
Had to take prescription medications □ yes □ no
(If yes, name(s) of medication)
____________________________________________________________________________
Serious injury or illness □ yes □ no
Alcohol use □ yes □ no
Drug use □ yes □ no
Smoked cigarettes □ yes □ no
Had fever, rash, infection or other illness □ yes □ no
Had X-Rays □ yes □ no
Diabetes □ yes □ no
Other □ yes □ no
____________________________________________________________________________

C. Infant’s Health at Delivery
Trouble breathing □ yes □ no
Turned blue (cyanosis) □ yes □ no
Needed oxygen □ yes □ no
Turned yellow (jaundice) □ yes □ no
Required phototherapy □ yes □ no
Hospitalized after birth more than 7 days □ yes □ no
Why?____________________________________________________________________________
Birth defects □ yes □ no
Jittery □ yes □ no

Did your child require any special care shortly after birth □ yes □ no
(If yes, please describe; e.g., blood transfusions, oxygen, incubator, medications, etc.)
____________________________________________________________________________

D. Health History
In the first month of life did your child experience:
Infections □ yes □ no
Gagging, choking or vomiting often □ yes □ no
Difficulty sucking □ yes □ no
Medical History (continued):

Feeding problems □ yes □ no
Hospitalizations during the first month of life? □ yes □ no

If yes to any of the above please explain:
__________________________________________________________________________
__________________________________________________________________________

Hospitalizations after one month of life:

<table>
<thead>
<tr>
<th>Date</th>
<th>Reason</th>
<th>Length of Stay</th>
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<tbody>
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</tbody>
</table>

After the first month of life, has your child had any of these medical conditions? **Check if yes.**

<table>
<thead>
<tr>
<th>Speech problems</th>
<th>Frequent abdominal pain</th>
<th>Serious illness after immunizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye or vision problems</td>
<td>Frequent or severe headaches</td>
<td>Lead poisoning</td>
</tr>
<tr>
<td>Language problems</td>
<td>Chronic ear infections</td>
<td>Poisoning or overdose</td>
</tr>
<tr>
<td>Hearing difficulties</td>
<td>Pneumonia</td>
<td>Heart or blood pressure problems</td>
</tr>
<tr>
<td>Fine Motor problems (handwriting)</td>
<td>Meningitis</td>
<td>Asthma</td>
</tr>
<tr>
<td>Gross motor problems (clumsiness)</td>
<td>Kidney problems</td>
<td>Seizures (“fits”) / Neurologic Problems</td>
</tr>
<tr>
<td>Appetite or feeding problems</td>
<td>Broken bones</td>
<td>Head injury (knocked out)</td>
</tr>
<tr>
<td>Food allergies</td>
<td>Surgery (operations)</td>
<td>Sleeping Problems (too much or too little)</td>
</tr>
<tr>
<td>Other allergies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you checked yes to any of the above, please explain below: (i.e., if had surgery please explain what type and age of child)

- Is your child taking any medications on a regular basis? □ yes □ no

<table>
<thead>
<tr>
<th>Medications</th>
<th>Condition the medication is treating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>5.</td>
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</tbody>
</table>
**Developmental History:**

- At what age did your child:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sit without help?</td>
<td>Say single words meaningfully?</td>
</tr>
<tr>
<td>Crawl?</td>
<td>Combine 2 or more words?</td>
</tr>
<tr>
<td>Pull to a stand?</td>
<td>Combine 3 or more words?</td>
</tr>
<tr>
<td>Stand without help?</td>
<td>Use full sentences?</td>
</tr>
<tr>
<td>Cruise (walk holding on)</td>
<td>Use gestures to communicate?</td>
</tr>
<tr>
<td>Walking independently?</td>
<td>Use gestures with words?</td>
</tr>
<tr>
<td>Walk up/down stairs?</td>
<td>Show a hand preference?</td>
</tr>
<tr>
<td></td>
<td>Which hand?</td>
</tr>
</tbody>
</table>

- If your child is 5 years of age and younger:

  - How many words are in your child’s vocabulary? ________________________________
  - How much of what your child hears, does he understand? _______________________
  - How many steps in an instructions can your child follow? _______________________
  - How much of what your child says, can you understand? _________________________
  - How much of what your child says, can others understand? _______________________

- Compared to other children, do you feel that your child has been *slower* in learning:

  - To talk? [ ] yes [ ] no
  - To understand other people talk? [ ] yes [ ] no
  - To build with blocks, play with puzzles, draw pictures? [ ] yes [ ] no
  - Gross motor skills (walking, hopping, riding bicycles, etc)? [ ] yes [ ] no
  - Fine motor skills (fastening buttons, zippers, drawing, etc)? [ ] yes [ ] no
  - Early school-related skills (naming colors, alphabet, etc)? [ ] yes [ ] no
  - To play or socialize with other children? [ ] yes [ ] no

- As an infant, was your child fussy? [ ] yes [ ] no
  - Difficult to rouse/over sleepy? [ ] yes [ ] no
  - Unresponsive when cuddled? [ ] yes [ ] no

- Has this child had difficulty separating from caregivers? [ ] yes [ ] no
  - What age? ______

- Is your child toilet trained? [ ] yes [ ] no
  - What age? ______

- Does your child have toileting accidents *during the day*? [ ] yes [ ] no
  - How often? ______________

- Does your child have any toileting accidents *during the night*? [ ] yes [ ] no
  - How often? ______________

- Does your child have sleeping difficulties? [ ] yes [ ] no
  - (i.e. Difficulty going to bed, falling and/or staying asleep?) Please describe: __________________________

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Page 9 of 13
Developmental History (continued):

- Does your child have any eating difficulties? □ yes □ no
  Please describe: ____________________________________________________________

- Does your child have the opportunity to play with same-age children? □ yes □ no

- What toys or activities does your child seem to enjoy?
  _________________________________________________________________________
  _________________________________________________________________________
  _________________________________________________________________________

Educational History:

Did your child attend preschool? □ yes □ no

Age of Attendance(s): _________________________ School: _________________________

Problems reported in Pre-school: ____________________________________________

Did your child attend special needs preschool? □ yes □ no

Age of Attendance(s): _________________________ School: _________________________

Please provide a copy of preschool multidisciplinary evaluation.

- Age at Kindergarten entrance: _________________________ School: _________________________

Problems reported in Kindergarten: __________________________________________

- Has your child ever repeated a grade? □ yes □ no
  If yes, what grades? ______________________________________________________

- Has your child had a frequent change of schools? □ yes □ no
  If yes, how many schools has he/she attended? ________________________________

- Current grade placement: _________________________

- School’s name: __________________________________________________________
  _______________________________________________________________________

Has your child received or is currently receiving any of the following services:

Please provide copies of all evaluations that have occurred over the past 5 years such as speech, occupational or physical therapy, psycho-educational, neuropsychological, etc.,

Speech/language therapy □ yes □ no _________________________
Physical Therapy □ yes □ no _________________________
Occupational Therapy □ yes □ no _________________________
Learning Disabilities Tutoring □ yes □ no _________________________
Counseling □ yes □ no _________________________
Others, please describe: ____________________________________________________

Ages or Grades

Page 10 of 13
Educational History (continued):

- Has your child ever been placed in a special educational program?
  
  Please provide copies of all evaluations.

  Developmental Preschool  □ yes  □ no
  Emotional Handicapped     □ yes  □ no
  Mental Handicapped/Retardation □ yes  □ no
  Learning Disabilities Resource room □ yes  □ no
  Multiple Handicapped      □ yes  □ no
  Hearing Impaired          □ yes  □ no
  Visually Impaired          □ yes  □ no

If your child is 5 years of age and older and in school, please indicate how your child is doing in each of these areas:

<table>
<thead>
<tr>
<th></th>
<th>Serious Problem</th>
<th>Below Average</th>
<th>Average</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td></td>
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<tr>
<td>Spelling</td>
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<td>Math</td>
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<td>Writing</td>
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<tr>
<td>Behavior</td>
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<td>Athletics</td>
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<tr>
<td>Attendance</td>
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<tr>
<td>Turning in assignments</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Social or friends</td>
<td></td>
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</tr>
</tbody>
</table>

If appropriate, is your child involved in any vocational education?

□ Yes  □ No  □ Not Applicable

Difficulties for the Referred Child:

Does your child experience any of the following?

- Difficulty starting tasks
- Difficulty completing tasks
- Impulsivity (acts without thinking)
- Temper outbursts
- Low frustration tolerance
- Difficulty playing quietly
- Talks excessively
- Loses things
- Doesn’t listen
- Engages in dangerous behavior
- Doesn’t learn from experience
- Poor memory
- Prefers to play by themselves
- Poor eye contact
- Failure to turn when name is called
- Argues with adults
- Angry
- Perfectionistic or particular about certain things
___ Difficulty with changes in routine
___ Difficulty transitioning from one environment to another or one activity to another.
___ Sensitivity to sounds (Does your child react negatively to surprising or loud sounds, (i.e.: cries or hides at noise from vacuum cleaner, dog barking, hair dryer?)
___ Does your child have trouble focusing if there is a lot of noise around?
___ Sensitivity to touch (Does your child show signs of distress during grooming, i.e.: fights or cries during hair brushing, face washing, teeth brushing?)
___ Is your child a picky eater (i.e.: will not try new textures, will not eat due to a different smell, etc)?
___ More interested in things vs people
___ Difficulty taking turns
___ Does your child fidget/can’t sit still so much that it is interfering with daily routines?
___ Shifts from one uncompleted activity to another
___ Nightmares
___ Temper tantrums (throwing things, screaming, banging head)
___ Overactive or restless; into things more than someone of that age
___ Inattentive; difficulties concentrating, off task
___ Difficulty starting tasks
___ Safety concerns (child running out of house/wandering, running into street)
___ Concerns or difficulty with, feeding, dressing self, grooming, etc.
___ Poor relatedness with other family members
___ Seems depressed / Sad
___ Has low self-esteem
___ Easily bored
___ Is anxious/nervous
___ Relevant Pain issues
___ Abuse History (sexual or physical)
___ Been involved in the legal system
___ Difficulty making or keeping friends
___ Acts younger than their age in social situations
Any other concerns not mentioned __________________________________________________

Has your child ever been seen by a psychologist, psychiatrist, or counselor? _____ YES      _______ NO
If yes, at what age? ____________________________________________________________________
For how long were they treated? __________________________________________________________

Please indicate whether your child has ever been diagnosed with any of the following conditions, approximately what age they were diagnosed, and what type of professional made the diagnosis (i.e. pediatrician, psychiatrist, etc).

- ADD, AD/HD  [ ] yes  [ ] no  Age at diagnosis_______ By whom___________________________
- Learning disability  [ ] yes  [ ] no  Age at diagnosis_______ By whom___________________________
- Depression  [ ] yes  [ ] no  Age at diagnosis_______ By whom___________________________
- Anxiety  [ ] yes  [ ] no  Age at diagnosis_______ By whom___________________________
- Autism/ Asperger’s  [ ] yes  [ ] no  Age at diagnosis_______ By whom___________________________
- Other Mental Health  [ ] yes  [ ] no  Age at diagnosis_______ By whom___________________________

Please specify which
**Discipline:**

Please check below the types of discipline used at home for your child’s behavior:

<table>
<thead>
<tr>
<th>Discipline</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Time out</td>
<td></td>
</tr>
<tr>
<td>Talking it out</td>
<td></td>
</tr>
<tr>
<td>Taking things away</td>
<td></td>
</tr>
<tr>
<td>Yelling</td>
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<tr>
<td>Spanking</td>
<td></td>
</tr>
<tr>
<td>Ignoring</td>
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</tr>
<tr>
<td>Grounding</td>
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</tr>
<tr>
<td>Extra Chores</td>
<td></td>
</tr>
<tr>
<td>Praise/reward good behavior</td>
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</tbody>
</table>

Please comment on the effectiveness of the methods you use:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

What do you enjoy most about raising your child:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

What do you find the most difficult about raising this child:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Additional Information**

Please add any additional information that you believe will help us to better understand your child.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Thank you for taking the time to complete this form. Please send this back along with any additional paperwork and reports, including previous evaluations, IEP, etc. We are looking forward to meeting with you and your child in our Developmental-Behavioral Pediatrics Clinic!