



Behavioral/Developmental Patient History

Child's Name: _____

Parent(s) completing this form: _____

What are you hoping we can help you with?: _____

Please check the appropriate answer. Use the line following to give additional information.

PAST HEALTH HISTORY

A. Pregnancy/Birth

1. Did the mother have any illnesses or problems during pregnancy with this child? Yes No

If yes, please explain: _____

2. How old was the mother when this child was born? _____ years old

3. How much weight did the mother gain during the pregnancy with this child? _____ Pounds

4. Did the mother use any of the following during the pregnancy with this child?

Alcohol Yes No How much? _____

Cigarettes Yes No How much? _____

Street Drugs Yes No How much? _____

Caffeine Yes No How much? _____

Prescription Medications Yes No What kind(s)? _____

How much? _____

5. Type of birth: Vaginal Caesarean

6. Were there any problems during labor or delivery? Yes No

Was the baby breech (feet first)? Yes No

Were forceps used? Yes No

Was labor induced? Yes No

7. Was this child born prematurely Yes No How early? _____

8. Baby's birth weight: _____ pounds _____ ounces

9. Did baby or mother have any problems when in the hospital? Yes No

If yes, please explain

10. Did the child require any special tests? Yes No

B. Child's Temperament

Please indicate (x) all that describe your child as an:

Infant (birth to 12 months of age)

Happy

Fussy

Cried little

Cried much

Easily comforted

Not easily comforted

Cuddly

Did not like to cuddle

Easy going

Demanding

Good sleeper

Poor sleeper

Normal activity level

Too active or inactive

Alert

Smiled little

Made many sounds

Quiet – did not make many sounds

Toddler (12 months to 36 months of age)

- | | |
|---|--|
| <input type="checkbox"/> Happy | <input type="checkbox"/> Fussy |
| <input type="checkbox"/> Cried little | <input type="checkbox"/> Cried much |
| <input type="checkbox"/> Easily comforted | <input type="checkbox"/> Not easily comforted |
| <input type="checkbox"/> Cuddly | <input type="checkbox"/> Did not like to cuddle |
| <input type="checkbox"/> Easy going | <input type="checkbox"/> Demanding |
| <input type="checkbox"/> Good sleeper | <input type="checkbox"/> Poor sleeper |
| <input type="checkbox"/> Normal activity level | <input type="checkbox"/> Too active or inactive |
| <input type="checkbox"/> Few Temper tantrums | <input type="checkbox"/> Many Temper tantrums |
| <input type="checkbox"/> Interacted with other children | <input type="checkbox"/> Isolated self from other children |

Preschooler (3 years to 5 years of age)

- | | |
|---|---|
| <input type="checkbox"/> Happy | <input type="checkbox"/> Fussy |
| <input type="checkbox"/> Cried little | <input type="checkbox"/> Cried much |
| <input type="checkbox"/> Easily comforted | <input type="checkbox"/> Not easily comforted |
| <input type="checkbox"/> Cuddly | <input type="checkbox"/> Did not like to cuddle |
| <input type="checkbox"/> Easy going | <input type="checkbox"/> Demanding |
| <input type="checkbox"/> Good sleeper | <input type="checkbox"/> Poor sleeper |
| <input type="checkbox"/> Normal activity level | <input type="checkbox"/> Too active or inactive |
| <input type="checkbox"/> Few Temper tantrums | <input type="checkbox"/> Many Temper tantrums |
| <input type="checkbox"/> Interacted with other children | <input type="checkbox"/> Isolated self from other children |
| <input type="checkbox"/> Smiled much | <input type="checkbox"/> Smiled little |
| <input type="checkbox"/> Talked much | <input type="checkbox"/> Quiet – did not talk much |
| <input type="checkbox"/> Easy to discipline | <input type="checkbox"/> Defiant of difficult to discipline |
| <input type="checkbox"/> Tried to please or make others happy | |

C. Developmental Milestones

1. Have you ever had concerns about your child's development? Yes No
If yes, please explain: _____
2. Have you ever had concerns about your child's vision? Yes No
3. Have you ever had concerns about your child's hearing? Yes No
4. At what age did your child do each of the following:

Sit Up	<input type="checkbox"/> 5-7 months	<input type="checkbox"/> 8-12 months	<input type="checkbox"/> Over 12 months	
Crawl	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> 13-18 months	<input type="checkbox"/> Over 18 months	
Walk	<input type="checkbox"/> 6-12 month	<input type="checkbox"/> 12-15 months	<input type="checkbox"/> Over 16 months	
Say single words (other than "mama" or "dada")	<input type="checkbox"/> 9-13 months	<input type="checkbox"/> 14-18 months	<input type="checkbox"/> 19-24 months	<input type="checkbox"/> Over 24 months
String two or more words together	<input type="checkbox"/> 9-13 months	<input type="checkbox"/> 14-18 months	<input type="checkbox"/> 19-24 months	<input type="checkbox"/> Over 24 months
Toilet trained (bladder/urine)	<input type="checkbox"/> 1-2 years	<input type="checkbox"/> 2-3 years	<input type="checkbox"/> 3-4 years	<input type="checkbox"/> Over 4 years
Toilet trained (bowel movement/BM)	<input type="checkbox"/> 1-2 years	<input type="checkbox"/> 2-3 years	<input type="checkbox"/> 3-4 years	<input type="checkbox"/> Over 4 years

D. Nutritional History

1. Was your child breast fed? Yes No How long? _____
2. Was your child formula fed? Yes No How long? _____
3. Did your child have any early feeding problems? Yes No
4. Was your child colicky? Yes No
5. At what age did your child start: Cow's milk Solid food Table food

6. Does your child have any food allergies or intolerances? Yes No

If yes, what: _____

E. MEDICAL HISTORY

1. Has your child had an allergic reaction to any of the following:

If yes, what was the reaction?

Medications _____

Animals _____

Trees _____

Molds _____

Dust _____

Insects _____

Tape _____

Latex _____

Other: _____

2. Has your child has (*please check all that apply*):

Hospitalization(s)

Frequent Respiratory Infection

Surgery(ies)

Sinus Infection(s)

Serious injury(ies)/accident(s)

Diabetes (Type 1 or Type 2)

Broken Bone(s)

Migraine Headaches

Stitches

Ear Infections

Fainting Episodes

Anemia (low iron in blood)

Head Injury(ies)

Asthma

Loss of Consciousness (knocked out)

Strep Throat

Concussion

Bladder/Kidney Infections

Meningitis

Mononucleosis

Chickenpox

Hay fever

Pneumonia

Measles

Seizures

Lead Poisoning

3. Has your child required any special tests? Yes No

4. Please list any other information about your child that your would like us to know?

F. MENTAL HEALTH HISTORY

1. Has your child ever had any counseling or psychological testing? Yes No

If yes, by whom? _____

2. Has your child ever been diagnosed as having any of the following conditions:

ADD/ADHD

Depression

Anxiety/Panic Disorder

Bipolar (Manic-depressive)

Conduct disorder

Oppositional defiant disorder

Chemical dependency

Sensory defensiveness / sensory integration

Attachment disorder

Obsessive compulsive disorder

3. Has your child ever been prescribed medications for mental health or behavioral reasons?

Yes No If yes, what medications? _____

CURRENT HEALTH HISTORY

1. Please list any medications your child takes on a regular basis: _____

2. Has your child had all their immunizations (shots)? Yes No

A. Nutrition

1. How well does your child eat? Excellent Good Fair Poor

2. List any concerns you have about your child's eating

3. Does your child take vitamins? Yes No

4. Rate how your child eats these foods:

- | | | | |
|---------------------|-------------------------------|-------------------------------|-------------------------------|
| Milk/dairy: | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Fruit: | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Vegetables: | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Bread/Cereal/Pasta: | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |

5. Does your child have any food intolerances? Yes No

6. How many times per day does your child eat sweets, chips, junk foods, etc? _____

7. Does your child sit at the table for the entire family meal? Yes No

8. Check all that apply to your child:

- | | |
|--|---|
| <input type="checkbox"/> Eats too much | <input type="checkbox"/> Avoids food |
| <input type="checkbox"/> Eats too little | <input type="checkbox"/> Avoids foods of certain temperatures |
| <input type="checkbox"/> Avoids spicy foods | <input type="checkbox"/> Prefers bland foods |
| <input type="checkbox"/> Eats non-food items | |

B. Elimination

1. How often does your child have a stool? _____

2. Check all that apply to your child:

- | | | |
|--|--|--|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Pain when urinating | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Urinating frequently in small amounts | <input type="checkbox"/> Urinates in underwear | |
| <input type="checkbox"/> Stools in underwear | | |

C. Sleep

1. What time does your child go to sleep at night? _____ Up in the morning? _____

2. Does your child nap during the day? Yes No Length of nap _____

3. Check all that apply to your child:

- | | |
|--|--|
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Restless sleeper |
| <input type="checkbox"/> Afraid of the dark | <input type="checkbox"/> Awakens frequently during the night |
| <input type="checkbox"/> Afraid to sleep alone | <input type="checkbox"/> Very early riser |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Always tired, even after a good night's sleep |

D. Dental

1. Does your child brush his/her teeth? Yes No When: _____

2. Does your child floss his/her teeth? Yes No When: _____

3. Date of last dental visit: _____ Any dental concerns: _____

4. Type of water: City Well Water Bottled water

If well water, does your child take fluoride? Yes No

E. Review of Systems

Check is your child has any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Pain in ears | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Drainage from ears | <input type="checkbox"/> Chest pain with exercise |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Difficulty hearing | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Bruises easily | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Poor activity level/tires easily |
| <input type="checkbox"/> Birthmark/moles | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Warts | <input type="checkbox"/> Frequent runny/stuffy nose | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Frequent bloody nose | <input type="checkbox"/> Stomach cramps/pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Frequent sore throat | <input type="checkbox"/> Joint pain/stiffness swelling |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Hoarse sounding voice | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Scoliosis (curvature of spine) |
| <input type="checkbox"/> Loss of eyesight | <input type="checkbox"/> Frequent cough | |

- Tics (uncontrolled muscle movements)
- Blurry vision/difficulty seeing
- Wheeze or cough during or after exercise

FAMILY HISTORY

- Child is adopted, family history unknown.
- Father is adopted, father's family history is unknown.
- Mother is adopted, mother's family history is unknown.

1. Are parents in good health? Yes No

2. Check any conditions that the child's parents, grandparents, siblings, aunts or uncles have had:

- | | | |
|---|---|---|
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Vision problems/crossed eyes | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Hearing problems/deafness | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Allergy/hay fever |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart problems/heart attacks | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Alcohol or drug problems |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Sudden death during exercise |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scoliosis (curvature of spine) | <input type="checkbox"/> Reading problems |
| <input type="checkbox"/> Trouble with the law | <input type="checkbox"/> Cancer | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> Sickle cell | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Depression | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Bipolar (manic-depressive) | <input type="checkbox"/> Tics/tourettes | |

FAMILY/SOCIAL

1. Who lives in the household with the child being evaluated? Please list names and ages:

Mother _____	Father _____
Brother _____ Age _____	Sister _____ Age _____
Brother _____ Age _____	Sister _____ Age _____
Brother _____ Age _____	Sister _____ Age _____
Brother _____ Age _____	Sister _____ Age _____
Other _____	

2. Parents are: Married Separated Divorced Living together Never married
 Other – explain: _____

3. How does the child get along with parents?
 Better than average Average Worse than average

4. How does the child get along with their brother(s)/sister(s)
 Doesn't have any siblings Better than average Average Worse than average

5. Check which stressful family events have occurred within the past 12 months:

- | | |
|---|--|
| <input type="checkbox"/> Parents divorced or separated | <input type="checkbox"/> Death in family |
| <input type="checkbox"/> Family accident or illness | <input type="checkbox"/> Family moved |
| <input type="checkbox"/> Parent changed job | <input type="checkbox"/> Family financial problems |
| <input type="checkbox"/> Parent received treatment for alcohol or drug abuse | |
| <input type="checkbox"/> Parent received treatment for depression or other mental illness | |

Other – explain: _____

6. How easily does your child make friends?
 Easily Average Very difficult
7. On an average, how long does your child keep friendships?
 Less than 6 months 6 months to 1 year greater than 1 year
8. Does your child become aggressive (push, shove or hit) when around friends? Yes/no
9. Do children refuse to play with your child yes/no

SCHOOL HISTORY

1. Does your child like school? Yes No
2. Has your child refused to go to school? Yes No
3. How many schools has your child attended? _____
4. Has your child repeated a grade in school? Yes No If yes, which grade(s) _____
5. Has your child ever had any serious behavioral or discipline problems at school? Yes No
6. Has your child ever been suspended or expelled from school yes/no
7. Check any of the school programs your child has been involved in:
 Special education, how long? _____
 Learning disabilities, how long? _____
 Resource room, how long? _____
 Title/Chapter 1, how long? _____
 Speech and language therapy, how long? _____
 Emotional behavioral disorder classes, how long? _____
 Private tutoring, how long? _____
 Other, please specify: _____
8. Does your child have an IEP (individual Educational Plan) at school? Yes No
9. What does your child do well in school? _____
10. What concerns do you have related to your child's work in school? _____
11. What concerns do the teachers have about your child? _____

Please summarize your child's academic and social progress (how they got along with peers) in each grade; comment on any concerns mentioned by the child's teachers.

Preschool:

Kindergarten:

Grades 1 through 3:

Grades 4 through 6:

Grades 7 through 12:

BEHAVIOR

1. Please check the characteristics that your child has:

- | | |
|--|--|
| <input type="checkbox"/> Fidgets/constantly moving | <input type="checkbox"/> Often interrupts or intrudes on others |
| <input type="checkbox"/> Difficulty sitting still | <input type="checkbox"/> Does not seem to listen |
| <input type="checkbox"/> Is easily distracted | <input type="checkbox"/> Loses things frequently |
| <input type="checkbox"/> Has difficulty waiting his/her turn | <input type="checkbox"/> Makes careless mistakes in school work |
| <input type="checkbox"/> Forgets homework at school or home | <input type="checkbox"/> Has difficulty paying attention |
| <input type="checkbox"/> Has difficulty following instructions | <input type="checkbox"/> Often moves from one activity to another |
| <input type="checkbox"/> Has difficulty playing quietly | <input type="checkbox"/> Often argues with adults |
| <input type="checkbox"/> Has difficulty finishing chores or school work | <input type="checkbox"/> Often angry or resentful |
| <input type="checkbox"/> Often loses temper | <input type="checkbox"/> Often deliberately annoys others |
| <input type="checkbox"/> Often blames others for mistakes | <input type="checkbox"/> Often refuses adult guidance or rules/disobedient |
| <input type="checkbox"/> Often touchy or easily annoyed | <input type="checkbox"/> Steals |
| <input type="checkbox"/> Lies often | <input type="checkbox"/> Has used a weapon in a fight |
| <input type="checkbox"/> Cruel to animals | <input type="checkbox"/> Has destroyed property |
| <input type="checkbox"/> Cruel to people | <input type="checkbox"/> Has set fires |
| <input type="checkbox"/> Has run away from home | <input type="checkbox"/> Often starts fights |
| <input type="checkbox"/> Often truant-skips school | <input type="checkbox"/> Seems sad or depressed |
| <input type="checkbox"/> Has gotten into trouble with the "law" | <input type="checkbox"/> Poor appetite or overeating |
| <input type="checkbox"/> Cries easily and often | <input type="checkbox"/> Does not seem to enjoy usual activities |
| <input type="checkbox"/> Often tired/loss of energy | <input type="checkbox"/> Trouble sleeping – not able to sleep or sleeps too much |
| <input type="checkbox"/> Not able to concentrate | <input type="checkbox"/> Has feelings of hopelessness |
| <input type="checkbox"/> Has mentioned thoughts of suicide or has made a suicide attempt | <input type="checkbox"/> Irritable almost every day |
| <input type="checkbox"/> Has low self-esteem | <input type="checkbox"/> Excessive or inappropriate guilt |
| <input type="checkbox"/> Has difficulty making decisions | <input type="checkbox"/> Often refuses to sleep alone |
| <input type="checkbox"/> Has feelings of worthlessness | <input type="checkbox"/> Worries about being separated from parents |
| <input type="checkbox"/> Frequently refuses to go to school | <input type="checkbox"/> Unable to relax-worries too much |
| <input type="checkbox"/> Afraid of being alone/clings to adults | <input type="checkbox"/> Worries about future events |
| <input type="checkbox"/> Worries about something happening to parents | <input type="checkbox"/> Has many fears or unusual fears |
| <input type="checkbox"/> Needs constant reassurance | <input type="checkbox"/> Is extremely shy |
| <input type="checkbox"/> Overly cautious | <input type="checkbox"/> Self-mutilation – hurts self |
| <input type="checkbox"/> Feels incompetent | <input type="checkbox"/> Does not like being touched |
| <input type="checkbox"/> Has panic attacks | <input type="checkbox"/> No or delayed reaction to pain |
| <input type="checkbox"/> Disoriented, confused or "spacey" | <input type="checkbox"/> Does not like certain textures of clothes |
| <input type="checkbox"/> Overreacts to touch | <input type="checkbox"/> Isolates self from other children |
| <input type="checkbox"/> No or excessive reaction to noise | <input type="checkbox"/> Likes to smell people and things |
| <input type="checkbox"/> Prefers to be naked | <input type="checkbox"/> Overly sensitive to bright lights |
| <input type="checkbox"/> Talks excessively or loudly | <input type="checkbox"/> Sucks thumb |
| <input type="checkbox"/> Overreacts to odor | <input type="checkbox"/> Refuses grooming (combing hair, brushing teeth, bathing, cutting fingernails, etc.) |
| <input type="checkbox"/> Bites fingernails | |
| <input type="checkbox"/> Talks excessively | |

Are there any additional concerns you have regarding your child? If so, please explain:
