COMPLETE CHILDREN'S HEALTH

Initial Behavior Clinic Form

Child's Name: _____

Parent/Caregiver Name(s): _____

Parent/Caregiver(s) Occupations: _____

Who all lives in the home (please include sibling's ages):

_____

_____

Child's School: _____ City/State: _____ Grade: _____

Child's Primary Care Physician: _____

If not Complete Children's Health, please provide physician's phone #: _____

How were you referred to your appointment today? _____

What is the reason for your child's appointment today?

_____

_____

_____

EARLY BEHAVIOR INDICATORS

When did you first notice something was "not quite right?" _____

Anything "unusual" at the following ages? If so, please list below.

0-2 years old _____

3-5 years old _____

> 5 years old _____

Did your child meet his developmental milestones at an age-appropriate level? Yes No

If you answered no to the above question, please explain below:

_____

_____

If you do not understand any of these questions, please ask your nurse.

HEALTH HISTORY

Were there any problems with mom during pregnancy with this child?

_____

_____

Was your child born at 37-40 weeks gestation, or was your child born earlier than 37 weeks gestation?

_____

Were there any problems with your child after birth?

_____

Was your child adopted? _____ If so, at what age were they adopted? _____

Does your child have any existing/chronic medical problems or conditions? Yes No

If yes, please list:

_____

Has your child ever had to stay in the hospital overnight or longer? Yes No

If yes, please include date, reason, and location for each hospitalization:

_____

_____

Is there a family history of any significant medical or mental disorders? Yes No

If yes, please explain:

_____

Has your child had any genetic or medical testing done in the past? Yes No

If yes, please include what type of testing, and by whom it was completed:

_____

Has your child had any previous psychological or academic evaluations? Yes No

If yes, please include when, by whom, and what type of evaluation was completed:

_____

Does your child currently have a psychiatric diagnosis (i.e. ADHD, Autism, OCD, etc.)? Yes No

If yes, please list:

_____

Is your child/family currently seeing a counselor/psychiatrist or receiving any physical, occupational, speech, or behavioral therapies? Yes No

If yes, please list what therapies your child is receiving and by whom:

_____

_____

Does your child have an Individualized Education Plan (IEP)? Yes No

If yes, please include what diagnosis your child has for this IEP, and when the last meeting you had with school for an IEP:

_____

_____

If you do not understand any of these questions, please ask your nurse.

BEHAVIOR SYMPTOM INVENTORY

Please place an "X" next to any behaviors noted below that you think describe your child in his/her lifetime.

Social Interaction Difficulties ___ poor eye contact ___ ignores other when called ___ in his/her own world ___ lack of curiosity ___ facial expressions don't fit situation ___ lack of ability to imitate ___ sees the world in "black" and "white" ___ inappropriate tears/laughter/emotions ___ does not understand other's feelings ___ temper tantrums ___ inappropriately anxious/fearful ___ hates crowds ___ more comfortable around adults ___ difficulty with peer relationships	**Motor Skills** ___ holds a pencil "funny" ___ difficulty taking notes/writing ___ walks on tip-toes ___ clumsy body posture ___ low muscle tone ___ drooling or swallowing difficulties
Communication Difficulties ___ loss of acquired speech ___ produces unusual noises/gibberish ___ voice louder than required ___ monotonous tone ___ no spontaneous initiation of speech ___ repetitive language or "movie talk" ___ uses language inappropriately ___ does not understand nuances of speech ___ pulls parents when wants something ___ uses gestures to express needs, not words ___ angry when needs not communicated and met	**Sensory** ___ sensitive to food textures/tastes ___ sensitive to clothing (tags, tightness) ___ sensitive to bright lights ___ sensitive to loud noises ___ sensitive to certain smells ___ does not like to be touched ___ hand flapping ___ head banging ___ ignores or does not seem to feel pain
Symbolic Play ___ arranges toys in rows ___ spins objects or self ___ smells, bangs, or licks toys ___ obsessed with toy parts ___ does not "pretend" ___ difficulty stopping repetitive activity ___ obsessed with objects/topics ___ restricted interest (toy, movie, topic) ___ stubborn about rituals/routines	**Toileting Issues** ___ day time wetting ___ enuresis (bed wetting) ___ encopresis (stool accident/soiling) ___ stool smearing

If you do not understand any of these questions, please ask your nurse.

BEHAVIOR SYMPTOMS INVENTORY CONTINUED

Please place an "X" next to any behaviors noted below that you think describe your child in his/her lifetime.

Short Attention Span ___ lack of focus ___ needs frequent reminders ___ easily distracted	**Impulsive** ___ acts without thinking ___ trouble waiting his turn ___ disruptive
Hyperactive ___ can't sit still ___ always on the go ___ fidgets	**Oppositional** ___ argues ___ loses temper/outbursts ___ blames others ___ intense
Anxious ___ cries frequently/easily ___ fearful of new situations ___ panic/worries over small things	**Conduct Disorder** ___ lies, steals ___ often gets into fights ___ cruel to people/animals ___ self injury ___ fire setting
Adjustment Problems ___ has trouble with new circumstances or situations	**Depression** ___ often seems sad ___ cries often ___ pessimistic

ADDITIONAL AREAS OF CONCERN

Learning ___ memory ___ math ___ spelling ___ attention ___ distractibility ___ motivation ___ expressive language (written and/or verbal) ___ receptive language (spoken and/or read) ___ motor skills	**School** ___ absenteeism ___ class work completion ___ homework completion ___ inconsistent performance ___ test taking ___ unhappy at school	**Social** ___ anger control ___ disobedience ___ disruptive behavior ___ immaturity (compared to peers) ___ peer relationships ___ risk-taking ___ poor self-esteem ___ hyperactivity

If you do not understand any of these questions, please ask your nurse.

FURTHER AREAS OF CONCERN

If there are further areas of concern that were not covered in the above checklists, or you would like to describe them in more detail, please feel free to do so below.

Family:

_____

Social Relationships:

_____

Academics/School/Learning:

_____

Speech/Language/Communication:

_____

Sleep:

_____

Appetite/Eating:

_____

Sensory (hearing, vision, touch/texture, smell, taste):

_____

Toileting:

_____

Rituals/Routines/Obsessions:

_____

Other:

_____

What are your child's strengths?

_____

What does your child enjoy doing?

_____

CURRENT MEDICATIONS

Please list all medications that your child takes currently. Please include over the counter medications and supplements/vitamins.

Medication	Dose	When given	Prescribing Doctor

If you do not understand any of these questions, please ask your nurse.