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BEHAVIOR & ADHD SCREENING INTAKE FORM

PATIENT

NAME: ____ TODAYS DATE ______/______/__________
LAST FIRST MI

DATE OF BIRTH: ______/______/_______ AGE: _____ GRADE LEVEL:_____ SCHOOL:_________________________________

PERSON COMPLETING FORM: MOTHER / FATHER / GUARDIAN / OTHER: ____

MOTHER

NAME: ____
LAST FIRST

AGE_______ MARITAL STUTUS: ______________________

OCCUPATION ______________________________________

HIGHEST EDUCATION LEVEL _________________________

ACADEMIC DIFFICULTIES? ___________________________

PHONE (______) __________ - _______________________

FATHER

NAME: ____
LAST FIRST

AGE_____ MARITAL STUTUS: _______________________

OCCUPATION _____________________________________

HIGHEST EDUCATION LEVEL ________________________

ACADEMIC DIFFICULTIES? __________________________

PHONE (______) __________ - _____________________

ADDITIONAL CARETAKERS, RELATIONSHIP & PHONE NUMBER

____

____

____

PRIMARY CONCERNS FROM PARENT:

1) ____ 3) ____

2) ____ 4) ____

AGE OF ONSET OF SYMPTOMS: __________________ DURATION OF PROBLEM BEHAVIOR ___________________________

FREQUENCY THAT BEHAVIOR IS A CONCERN: DAILY / 1-3 TIMES A WEEK / WEEKLY / MONTHLY

SITUATIONS THAT WORSEN BEHAVIOR: ____

____

SITUATIONS THAT IMPROVE BEHAVIOR: ____

____

PREVIOUS TREATMENT AND RESULTS: ____

____

PRIOR SERVICES

	WHERE WERE SERVICES COMPLETED	NAME OF SERVICE PROVIDER
______ COUNSELING OR THERAPY	______________________________	______________________________
______ IEP OR 504 PLAN	______________________________	______________________________
______ BEHAVIOR EVALUATION	______________________________	______________________________
______ LEARNING DISORDER EVALUATION	______________________________	______________________________

CURRENT MEDICATIONS:

PRESCRIPTION ____

OVER THE COUNTER ____

SUPPLEMENTS ____

PRENATAL HISTORY LIST ALL OF MOTHER'S PREGNANCIES – INCLUDE MISCARRIAGES

YEAR	SEX	LENGTH OF PREGNANCY	BIRTH WEIGHT	VAGINAL/ C-SECTION	COMPLICATIONS

1) ____

2) ____

3) ____

4) ____

PAST MEDICAL HISTORY

PRENATAL: CHECK ANY OF THE FOLLOWING WHICH OCCURRED DURING THE PREGNANCY OF THIS CHILD:

_____ HIGH BLOOD PRESSURE _____ HIGH FEVER _____ HOSPITALIZATION

_____ INFLUENZA _____ VAGINAL BLEEDING _____ ACCIDENTS / FALLS

_____ INFECTIONS _____ AMNIOCENTESIS

CHECK ANY MEDICATIONS / SUBSTANCES USED DURING THE PREGNANCY OF THIS CHILD:

_____ ANTIBIOTICS _____ PRENATAL VITAMINS _____ OTC COLD MEDICINE

_____ SEIZURE MEDICATION _____THYROID MEDICATION _____ TOBACCO

_____ MARIJUANA _____ ALCOHOL _____ AMPHETAMINES

_____ COCAINE _____ OTHER ____

BIRTH HISTORY: WAS THIS CHILD BORN PREMATURE? YES / NO

IF YES, WHAT WAS GESTATION ______ WEEKS ______ DAYS MATERNAL AGE AT DELIVERY ___________

APGAR SCORES: 1 MIN _____ 5 MIN _____ LABOR: ______INDUCED ______ SPONTANEOUS ______ GENERAL ANESTHESIA

NEWBORN PROBLEMS:

______ ANEMIA ______JAUNDICE ______PHOTOTHERAPY ______NEEDED OXYGEN ______INFECTION

______HOSPITALIZED IN NICU OR SPECIALTY CARE OR ANY VENTILATOR USE? _______________________________

____

PREVIOUS DIAGNOSIS

______ CHRONIC EAR INFECTIONS ______ HEARING PROBLEMS ______ ASTHMA

______ EYE PROBLEMS ______ SINUS INFECTIONS ______ TIC DISORDER

______ MENINGITIS ______ SEIZURES ______ PROLONGED OR HIGH FEVER

_____ IRON DEFICIENCY _____ HEART MURMUR _____ HEART PALPITATIONS

_____ HIGH BLOOD PRESSURE _____ HEADACHES _____ ENLARGEMENT OF ADENOIDS/TONSILS

_____ ABDOMINAL PAIN _____ CHRONIC CONSTIPATION _____ CHRONIC DIARRHEA

_____ HEAD TRAUMA / CONCUSSION _____ SPEECH / LANGUAGE DELAYS OR DIFFICULTIES

PAST SURGICAL HISTORY

SURGERY PREFORMED	DATE OF SURGERY	NAME OF SURGEON AND/OR FACILITY
____	_____/______/_____	______________________________
____	_____/______/_____	______________________________

STRESSORS (FAMILY STRESS OR PROBLEMATIC RELATIONSHIPS, BULLYING, SOCIAL PRESSURES, ETC)

IF ANY PLEASE EXPLAIN____

____

DEVELOPMENT AGE OF CHILD:______

_____ SAT WITHOUT SUPPORT _____ SPOKE SINGLE WORDS _____TIED SHOELACES

_____ CRAWLED _____ UNDRESSED SELF _____ FED SELF WITH SPOON

_____WALKED _____ PEDALED TRICYCLE _____ SPOKE SENTENCES

WAS THIS A "CUDDLY" BABY? ________ WAS THIS AN "ACTIVE" BABY? ________ WAS THIS A "COLIC" BABY? ________

TOILET TRAINING: AGE WHEN TOILET TRAINING WAS STARTED ____________ AGE COMPLETED __________

DOES YOUR CHILD HAVE ACCIDENTS DURING THE DAY OR NIGHT? _________________

SLEEP HABITS:

AGE CHILD BEGAN SLEEPING THROUGH THE NIGHT _________________

CURRENT BEDTIME ___________ CURRENT WAKE UP TIME __________ WHERE DOES CHILD SLEEP _________________

ANY CHANGES IN SLEEP IN THE PAST 6 MONTHS? ____

_____ NIGHT WAKING _____ NIGHTMARES OR NIGHT TERRORS _____ SLEEPWALKING _____ RESTLESS SLEEP

_____DIFFICULTY FALLING ASLEEP _____ APNEA (PAUSE IN BREATHING) _____ DAYTIME SLEEPINESS

_____WHAT ELECTRONICS ARE IN BEDROOM? ____

APPETITE:

_____ EATS CONSTANTLY _____ AVERAGE _____ PICKY EATER _____CAFFEINE USE

_____ WEIGHT LOSS OR WEIGHT GAIN, WHY?____

PROBLEMS AT MEALTIME: ____

JOBS/RESPONSIBILITIES

_____CHORES: PLEASE LIST ____

DOES YOUR CHILD COMPLY WITH DOING RESPONSIBILITIES AND CHORES? ______________________________

PLAY

WHO ARE YOUR CHILD'S BEST FRIENDS? ____

IS YOUR CHILD THE BEST FRIEND OF SOMEONE ELSE? ____

FAVORITE ACTIVITES ____

DISCIPLINE

______ SPANKING ______TIME OUT ______ SEND TO ROOM ______ WITHHOLD PRIVILEGES ______ REASONING

WHAT METHOD IS MOST EFFECTIVE? ____

DO PARENTS AGREE ON DISCIPLINE? EXPLAIN ____

ACEDEMIC HISTORY

	CHILD'S BEHAVIOR		
PRESCHOOL	______GOOD	______AVERAGE	______POOR
KINDERGARTEN	______GOOD	______AVERAGE	______POOR
GRADES 1-3	______GOOD	______AVERAGE	______POOR
CURRENT GRADE	______GOOD	______AVERAGE	______POOR

______ SCHOOL FAILURE OR REPEATED GRADE LEVEL ______PROBLEM WITH PREFORMANCE ON STANDARDIZED TESTS

______ CONCERN FOR LEARNING DISABILITY ______ DETENTION, SUSPENSION, OR EXPULSION

DOES YOUR CHILD HAVE OR EVER HAD AN IEP (INDIVIDUALIZED EDUCATION PLAN) OR A 504 PLAN? ______ YES ______ NO

IF YES, WHEN WAS IT LAST UPDATED? ____

REVIEW OF SYSTEMS

HAS YOUR CHILD EVER HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING:

CARDIAC:

______CHEST PAIN ______ SHORTNESS OF BREATH WITH EXERCISE ______ PALPITATIONS

______ FAINTING / DIZZINESS WITH EXERCISE ______ UNEXPLAINED OR NOTICABLE CHANGE IN EXERCISE TOLERANCE

NEUROLOGIC:

______RESTLESS LEG SYNDROME OR PERIODIC LIMB MOVEMENT DISORDER ______ SEIZURES

______ LEARNING DIFFICULTIES ______DEVELOPMENTAL DELAY

PSYCHIATRIC:

______ ANXIETY ______ DEPRESSION ______OPPOSITIONAL-DEFIANT DISORDER ______CONDUCT DISORDER

______DISRUPTIVE BEHAVIOR ______SUICIDAL THOUGHTS/ACTIONS ______ DELUSIONS ______MOOD INSTABILITY

______SUBSTANCE USE (CIGARETTES, ALCOHOL, DRUGS, PRESCRIPTION MEDICATIONS)

PREVENTATIVE SCREENINGS

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING STUDIES

______ EKG ______ ECHOCARDIOGRAM ______ GENETIC SCREENING ______ SLEEP STUDY

IF SO, WHERE? ____

FAMILY MEDICAL HISTORY

	YES	NO	WHO? Mother, Father, Sibling, Maternal / Paternal Grandparent, Maternal / Paternal Aunt or Uncle	Comments: Age diagnosed (if known)
ADHD				
ANEMIA				
ARRYTHMIA				
ASTHMA				
CANCER				
CARDIOMYOPATHY				
CONGENITAL BIRTH DEFECTS				
DEVELOPMENTAL DISABILITY				
DIABETES				
DRUG ALLERGY				
HIGH BLOOD PRESSURE				
HIGH CHOLESTEROL				
HEART DISEASE				
HEART ATTACK				
KIDNEY DISEASE				
LEARNING DELAY OR DISABILITY				
MENTAL ILLNESS/DEPRESSION				
MIGRAINES				
SEIZURES				
STROKE				
SUBSTANCE ABUSE				
SUDDEN DEATH <35 YEARS OF AGE				
THYROID DISORDERS				
OTHER:				