Pediatric Patient Form

Patient's Name: _____ Grade: _____ School: _____ IEP: Y/N
Parent/Guardian Here Today: _____ Best Contact Number: _____
Email: _____ Primary Care Physician (PCP): _____

1. Please circle YES or NO regarding CURRENT health problems/concerns.

Headaches	NO YES	Picky eater/limited diet/loss of appetite		NO	YES
Staring Spells/Tremors/Tics/Seizures	NO YES	Blood Sugar/Thyroid/Growth Problems		NO	YES
Hearing or Vision Concerns	NO YES	Skeletal/Bone/Muscle Problem/Toe Walking		NO	YES
Dental Problem	NO YES	Environmental Allergies		NO	YES
Heart Problems	NO YES	Skin Problems (rash, eczema)		NO	YES
Lung Problems (asthma)	NO YES	Sleep Problems (falling/staying asleep/snoring)		NO	YES
Urinary/Genital Problems	NO YES	Psychiatric Hospitalizations (last year)		NO	YES
Diarrhea/Constipation	NO YES	Toilet Trained:	**Day:** NO / YES **Night:** NO / YES **BM:** NO / YES		
Stomach Ache/Pain/Reflux	NO YES	Do you worry your child may run away from you?		NO	YES
Are there concerns with bullying?	NO YES	Do you feel your child is safe at home from abuse/neglect?		NO	YES
Have you had an EEG or MRI since last visit? If yes, please circle which one.				NO	YES

Please explain any current health problems/concerns: _____

_____

2. Please circle YES or NO for the following preventative care questions.

Regular well child visits with Primary Care Doctor (Pediatrician/Family Provider at least yearly)	NO	YES
Regular visits with Dentist (every 6 months or yearly)	NO	YES
Brushes teeth (at least once a day)	NO	YES
Vision checks (at least yearly)	NO	YES
Flu shot (yearly)	NO	YES
Immunizations up to date	NO	YES

3. Please circle the services, therapies or resources your child is receiving.

Regional Center (SB40, BCFR)	Easter Seals	Parent Training
Bureau of Special Health Care Needs	Physical Therapy (PT)	ABA / EIBI / Pivotal Response Training
First Steps / Parents as Teachers (PAT)	Occupational Therapy (OT)	Family Therapy / Counseling
PCIT (Parent-Child Interaction Therapy)	Speech Lang. Therapy (SLT)	Special Education / Learning Center / Resource Room / Private Tutoring
CBT (Cognitive Behavioral Therapy)	SSI	Social Skills Training / Peer Mediated Social Intervention
Other: _____	WIC	DIR (Developmental, Individual Differences, Relationship-Based)

4. If your child is on medications for behavior, please circle your goals for today's visit:

Stay the same / Decrease Medication / Increase Medication / Change Medication / Unsure

5. If your child is not on medication, are you considering medications as a treatment option? No / Maybe / Yes

6. Supplements/Special Diets: _____

7. Tell me one GREAT thing your child did last week. _____

_____

8. Tell me about your child's developmental progress since last seen. _____

_____

9. What questions would you like us to try to answer today?

1. _____
2. _____
3. _____

10. Is behavior a concern? YES **or** NO **(If YES, please complete the back of this form)**

CHILD BEHAVIOR SYMPTOMS

The purpose of this checklist is to help you decide which behavior(s) you feel are most important to discuss with your provider during your visit.

Behaviors:	How much of a problem?					What is the frequency of the behavior?					Where is it a problem?		What is your priority?
	Not at all	Mild	Moderate	Severe	Extremely Severe	Less than once per week	1-2 times per week	3-5 times per week	Every Day	Many times per day	At home	At school	Number your top 3 concern(s) that you want to discuss today (1st, 2nd, 3rd)
Hyperactivity (high activity level, "on the go," restless, fidgety)													
Impulsivity (acts without thinking, trouble keeping hands to self)													
Short attention span (unable to focus on tasks)													
Anxiety (too many fears, worries a lot)													
Irritability/Frequent Mood Changes (testy, grouchy, oversensitive)													
Repeating thoughts & behaviors (thinks about/does the same thing over & over, hand flapping, opening/closing)													
Depression/Sadness													
Noncompliant Behaviors													
Hurts himself/herself													
Tantrums/Aggression													
Elopement													
Other behaviors (please list):													