Covenant Clinic
Wheaton Franciscan Healthcare

Behavioral/Developmental Patient History

Child's Name: _____ DOB: _____

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) DOB: _____

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

Preschooler (3 years to 5 years of age)

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

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	❒ 5-7 months	❒ 8-12 months	❒ Over 12 months
Crawl	❒ 6-12 months	❒ 13-18 months	❒ Over 18 months
Walk	❒ 6-12 month	❒ 12-15 months	❒ Over 16 months

Say single words (other than "mama" or "dada")

❒ 9-13 months ❒ 14-18 months ❒ 19-24 months ❒ Over 24 months

String two or more words together

❒ 9-13 months ❒ 14-18 months ❒ 19-24 months ❒ Over 24 months

Toilet trained (bladder/urine)

❒ 1-2 years ❒ 2-3 years ❒ 3-4 years ❒ Over 4 years

Toilet trained (bowel movement/BM)

❒ 1-2 years ❒ 2-3 years ❒ 3-4 years ❒ 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 DOB: _____

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)
   - ❒ Surgery(ies)
   - ❒ Serious injury(ies)/accident(s)
   - ❒ Broken Bone(s)
   - ❒ Stitches
   - ❒ Fainting Episodes
   - ❒ Head Injury(ies)
   - ❒ Loss of Consciousness (knocked out)
   - ❒ Concussion
   - ❒ Meningitis
   - ❒ Chickenpox
   - ❒ Pneumonia
   - ❒ Seizures
   - ❒ Frequent Respiratory Infection
   - ❒ Sinus Infection(s)
   - ❒ Diabetes (Type 1 or Type 2)
   - ❒ Migraine Headaches
   - ❒ Ear Infections
   - ❒ Anemia (low iron in blood)
   - ❒ Asthma
   - ❒ Strep Throat
   - ❒ Bladder/Kidney Infections
   - ❒ Mononucleosis
   - ❒ Hay fever
   - ❒ Measles
   - ❒ 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:	❒ Good	❒ Fair	❒ Poor
Fruit:	❒ Good	❒ Fair	❒ Poor
Vegetables:	❒ Good	❒ Fair	❒ Poor
Bread/Cereal/Pasta:	❒ Good	❒ Fair	❒ Poor

DOB: _____

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:

❒ Eats too much ❒ Avoids food ❒ Avoids spicy foods ❒ Eats non-food items
❒ Eats too little ❒ Avoids foods of certain temperatures ❒ Prefers bland foods

B. Elimination

1. How often does your child have a stool? _____
2. Check all that apply to your child:

❒ Constipation ❒ Pain when urinating ❒ Urinating frequently in small amounts
❒ Diarrhea ❒ Bed wetting
❒ Stools in underwear ❒ Urinates in underwear
❒ Blood in stools ❒ Blood in urine

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:

❒ Difficulty falling asleep ❒ Restless sleeper
❒ Afraid of the dark ❒ Awakens frequently during the night
❒ Afraid to sleep alone ❒ Very early riser
❒ Nightmares ❒ 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:

❒ Acne
❒ Rashes
❒ Dry skin
❒ Bruises easily
❒ Birthmark/moles
❒ Warts
❒ Headaches
❒ Dizziness
❒ Double vision
❒ Red eyes
❒ Loss of eyesight
❒ Tics (uncontrolled muscle movements)
❒ Blurry vision/difficulty seeing
❒ Wheeze or cough during or after exercise
❒ Pain in ears
❒ Drainage from ears
❒ Difficulty hearing
❒ Ringing in the ears
❒ Hearing loss
❒ Frequent runny/stuffy nose
❒ Frequent bloody nose
❒ Frequent sore throat
❒ Hoarse sounding voice
❒ Difficulty breathing
❒ Frequent cough
❒ Heart murmur
❒ Chest pain with exercise
❒ High blood pressure
❒ Poor activity level/tires easily
❒ Nausea
❒ Vomiting
❒ Stomach cramps/pain
❒ Joint pain/stiffness swelling
❒ Leg pain
❒ Scoliosis (curvature of spine)

FAMILY HISTORY DOB: _____

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

Are parents in good health? ❒ Yes ❒ No

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

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

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:
   ❒ Parents divorced or separated ❒ Death in family
   ❒ Family accident or illness ❒ Family moved
   ❒ Parent changed job ❒ Family financial problems
   ❒ Parent received treatment for alcohol or drug abuse
   ❒ 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 DOB: _____

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 DOB: _____

Please check the characteristics that your child has:

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

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

_____

_____

_____

_____

_____