Family Pediatrics

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Child's Name:	
Date of Birth:	
Your Name:	
Your Relation to Child:	
Today's Date:	

1. Who has concerns regarding your child's behavior or concentrating? _____
_____
_____

2. How long have you had a concern regarding your child's behavior? _____
_____
_____

3. What are the main problems concerning?

- ☐ Not concentrating
- ☐ Poor behavior
- ☐ Both

4. Over time your child's behavior is *(select one)*:

- ☐ Getting Better
- ☐ Getting Worse
- ☐ Staying the Same

5. What are the 3 main problems your child his having at school?

A. _____
B. _____
C. _____

6. What are the 3 main problems your child is having at home?

A. _____
_____
B. _____
_____
C. _____
_____

7. What types of things have been done at school to help your child? _____

8. What types of things you do at home to help your child? _____

9. In what ways do you discipline your child? _____

10. Has your child received (or currently getting) any type of counseling? ☐ Yes ☐ No

If yes, please list type of counseling and how often.

_____

Tell us about your child

11. How many hours per day does your child play video games, watch TV and use the Internet?

12. Do you consider your child a loving child or a distant child? _____

13. Does your child make eye contact? _____

14. How does your child interact with other kids? _____

15. How does you child interact the adults? _____

16. How does your child treat animals/pets: _____

17. Is your child aggressive physically *(fighting or hitting others for example)*: ☐ Yes ☐ No

18. Has your child been in any legal trouble: ☐ Yes ☐ No

19. Is your child getting discipline at school due to behavior problems? ☐ Yes ☐ No

20. Overall, do you feel your child is:

- ☐ Happy
- ☐ Sad
- ☐ Neutral

21. What hobbies does your child have? _____
_____
_____
_____

22. What talents does your child have? _____
_____
_____
_____

23. Do you feel your child "blanks out" or stares off into space? _____
_____
_____
_____

24. Does your child snore a lot at night? _____
_____

25. Do you notice if your child stops breathing at night for a short while? _____
_____

26. How often is your child having bowel movements? _____
_____

27. Is your child's stool generally hard or soft? _____
_____

28. How is your child sleeping?

- ☐ sleeping well
- ☐ having problems sleeping

Tell us about your child's school performance

29. What kinds of grades does your child get?_____
_____

30. What subjects does your child do well in? _____
_____

31. What subjects does your child go badly in? _____
_____
_____

32. Does your child have an Individualized Education Plan at school? ☐ Yes ☐ No
_____
_____

33. Is your child in any special education classes? ☐ Yes ☐ No
If yes, please list them.
_____
_____

34. Does your child have any learning disabilities? ☐ Yes ☐ No
If yes, please list them.
_____
_____

Tell us about your child's medical conditions

35. Has your child ever been diagnosed with ADHD before? ☐ Yes ☐ No

If yes, has your child ever used medications before? ☐ Yes ☐ No

A. Is your child currently on any medications? ☐ Yes ☐ No

If yes, please list any medications your child uses and how they are given

Medication Name	Medication Dosage	Medication Directions

36. Has your child been diagnosed with any other conditions? ☐ Yes ☐ No
If yes, please list them.
_____
_____
_____
_____

37. Does your child take any ongoing medications? ☐ Yes ☐ No
If yes, please list them.

Medication Name	Medication Dosage	Medication Directions

38. Has your child ever had a hearing exam? ☐ Yes ☐ No

If yes, when approximately when was it done and what were the results:

Date of Testing	Type of Testing	Where was test performed?

39. Has your child ever had a vision exam? ☐ Yes ☐ No

If yes, approximately when was is done, and what were the results:

Date of Testing	Type of Testing	Where was test performed?

Tell us about your child's family history

40. How may other children you have? ☐ 1 ☐ 2 ☐ 3 ☐ 4+

41. Anyone in the family with any mental health conditions such as ADHD, learning disability, depression, etc? ☐ Yes ☐ No

If yes, please list their health condition and relationship to the patient.

Relationship to Patient	Health Condition(s)

Tell us about your child's family life

42. Who lives at home together where your child primarily lives?

_____
_____
_____
_____

43. Are there any recent changes in your family (example: moving, new job, new family member, etc.)?

_____
_____
_____
_____

44. Does your child live in a: ☐ single household ☐ split family arrangement

45. Please describe the stability of the household(s) that your child stays at?

_____
_____
_____
_____

46. Has your child ever been a victim of any type of abuse or witnessed any type of abuse?

☐ Yes ☐ No

If yes, please describe..

_____
_____
_____
_____

47. Has your child been a victim of any violence or exposed to violent situations?

☐ Yes ☐ No

If yes, please describe..

_____
_____
_____
_____

48. What kind of family activities do you do together?

_____
_____
_____
_____

49. If you have any additional concerns, questions or information not covered on this questionnaire, please describe them on the back of this page.