ADVANCED PEDIATRIC ASSOCIATES

Behavioral Assessment Questionnaire

Child's Name:____________________DOB:____________Age:_________Today's Date: ____________

Name of person completing this form:_______________________________Relationship:____________

In your own words, what is the reason for this visit? ____

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What help are you seeking from Advanced Pediatrics?____

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Is this evaluation for (check all that apply)?: ☐ First-Time Evaluation ☐ Second Opinion

☐ Updated Evaluation ☐ Consider Medication for ______________________

Please list any social workers, therapists, school staff, or other professionals currently involved in the child's welfare, or any educational plans in place: ____

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List any previous developmental, school, or mental health evaluations for the child—when, where, results: ____

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Is or has your child ever taken any medication for an emotional, behavioral, or mental health problem? If so, what and when? Include herbal or over-the-counter medication. ___________________________

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Family Medical History

Indicate any relatives of the child with any of the following problems.

	Brothers Sisters	Natural Mother	Mother's Relatives	Natural Father	Father's Relatives
Obsessive-Compulsive disorder or fussy habits, picky, rigid	☐	☐	☐	☐	☐
Tics or other nervous habits, Tourette's	☐	☐	☐	☐	☐
Depression for more than 2 weeks, medications for mood disorder	☐	☐	☐	☐	☐
Suicide or attempted suicide	☐	☐	☐	☐	☐
Psychosis or schizophrenia, hospitalized for mental or emotional problems	☐	☐	☐	☐	☐
Alcohol or drug abuse	☐	☐	☐	☐	☐
Legal problems, arrests, jail/prison time, court probations, "always in trouble"	☐	☐	☐	☐	☐
Serious or chronic medical problems: cancer, deafness, heart problems, seizures, diabetes, etc.	☐	☐	☐	☐	☐
Gambling, shopping or other compulsions	☐	☐	☐	☐	☐

Is there anything else we should know about your child or family?_______________________________

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