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## PATIENT/PARENT/GUARDIAN QUESTIONNAIRE

PATIENT: NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EDUCATION YEARS COMPLETED: \_\_\_\_\_

LEGAL CUSTODIAN: NAME: \_\_\_\_\_ RELATIONSHIP (TO PATIENT): \_\_\_\_\_

QUESTIONNAIRE INFORMANT: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ REFERRAL SOURCE: NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_ HAS YOUR CHILD UNDERGONE PRIOR EVALUATION(S) FOR

ACADEMIC OR OTHER DEVELOPMENTAL CONCERNS?: \_\_\_\_\_ IF SO, PLEASE PROVIDE

NAMES OF EXAMINERS AND DATES OF EVALUATION(S): NAME/DATES: \_\_\_\_\_

HOUSEHOLD FAMILY COMPOSITION (NAME/RELATIONSHIP/AGE): \_\_\_\_\_

BIOLOGIC PARENTS NAMES: MOTHER: \_\_\_\_\_ AGE: \_\_\_\_\_

FATHER: \_\_\_\_\_ AGE: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

DATE OF MARRIAGE: \_\_\_\_\_ DATE OF DIVORCE: \_\_\_\_\_

PARENTAL REMARRIAGE DATE: MOTHER: \_\_\_\_\_ FATHER: \_\_\_\_\_

AT WHAT PATIENT AGE DID ANYONE FIRST THINK THERE MAY BE PROBLEMS?: \_\_\_\_\_

WHO THOUGHT SO?: \_\_\_\_\_ FIRST PROBLEMS NOTED: \_\_\_\_\_

WHO SUGGESTED THIS EVALUATION?: \_\_\_\_\_

FOR WHAT PROBLEMS?: \_\_\_\_\_

PLEASE DESCRIBE/LIST THE CURRENT PROBLEMS AND QUESTIONS: \_\_\_\_\_

PLEASE INDICATE BY DESCRIPTION THE NATURE/CHARACTER/QUALITY OF THE FOLLOWING: SLEEP: \_\_\_\_\_ APPETITE: \_\_\_\_\_  
MOODS: \_\_\_\_\_ PEER RELATIONSHIPS: \_\_\_\_\_  
GRADES: \_\_\_\_\_ PARTICIPATION IN ORGANIZED PEER ACTIVITIES: \_\_\_\_\_

WEIGHT CHANGE?: \_\_\_\_\_ OVERALL PHYSICAL HEALTH: \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

PAST MEDICATIONS: \_\_\_\_\_

HAS THIS PATIENT EVER REQUIRED ONGOING PHYSICIAN/MEDICAL FOLLOWUP?: \_\_\_\_\_  
IF SO, DOCTOR'S NAME/DIAGNOSIS/DATES/TREATMENTS: \_\_\_\_\_

DOES THIS PATIENT CURRENTLY OR HAS THIS PATIENT EVER HAD PROBLEMS WITH ANY OF THE FOLLOWING (PLEASE INDICATE AGE PROBLEM FIRST APPEARED AND THE LAST AGE THE PROBLEM WAS NOTED): (e.g. : WETTING: AGE 4 YRS/ 7 YRS): WETTING: \_\_\_\_\_  
SOILING: \_\_\_\_\_

FIREPLAY: \_\_\_\_\_ SELF INJURIOUS BEHAVIOR: \_\_\_\_\_

AGGRESSIVE BEHAVIOR TOWARD OTHERS/SELF/ANIMALS: \_\_\_\_\_

HEAD BANGING: \_\_\_\_\_ ROCKING: \_\_\_\_\_  
SPINNING: \_\_\_\_\_ BITING: \_\_\_\_\_

UNREALISTIC FEARS: \_\_\_\_\_

EMOTIONAL IMMATURITY: \_\_\_\_\_

MOOD SWINGS: \_\_\_\_\_

DOES THIS PATIENT EVER SLEEP WITH OTHER PEOPLE?: \_\_\_\_\_ IF SO, WITH WHOM: \_\_\_\_\_

ANY HISTORY OR SUSPICION OF ANY TYPE OF ABUSE OR NEGLECT: \_\_\_\_\_  
(EMOTIONAL/PHYSICAL/SEXUAL): \_\_\_\_\_

PRIOR OR CURRENT USE OR SUSPICION OF USE OF ALCOHOL, DRUGS, OR TOBACCO?: \_\_\_\_\_  
IF SO, WHAT TYPES AND WHEN: \_\_\_\_\_

ARE THERE TIMES WHEN THIS PATIENT SHOULD BE AFRAID OF SOMETHING AND IS NOT: (e.g.: HEIGHTS/AUTOMOBILE TRAFFIC/STRANGERS)?: \_\_\_\_\_

WERE THERE ANY PROBLEMS OF ANY TYPE DURING THE PREGNANCY?: \_\_\_\_\_  
IF SO, WHAT TYPES AND WHEN?: \_\_\_\_\_

WERE THERE ANY PROBLEMS WITH LABOR AND DELIVERY?: \_\_\_\_\_  
IF SO, WHAT TYPES: \_\_\_\_\_

DID THIS PATIENT HAVE ANY PROBLEMS IMMEDIATELY FOLLOWING BIRTH?: \_\_\_\_\_  
IF SO, WHAT TYPES?: \_\_\_\_\_

LENGTH OF PREGNANCY?: \_\_\_\_\_ DELIVERY: VAGINAL: \_\_\_\_\_  
C-SECTION?: \_\_\_\_\_ (FOR WHAT REASONS): \_\_\_\_\_

BIRTH WEIGHT: \_\_\_\_\_ APGARS: 1 MINUTE: \_\_\_\_\_ 5 MINUTES: \_\_\_\_\_  
INFANT PRIMARY CARETAKER: \_\_\_\_\_

FEEDING: BREAST/BOTTLE: (INCLUDE DURATION OF EACH): \_\_\_\_\_

DURING THIS PATIENT'S FIRST 12 MONTHS, WERE THERE ANY PROBLEMS WITH:  
SLEEPING?: \_\_\_\_\_ FEEDING?: \_\_\_\_\_  
DID THIS PATIENT CRY TO BE HELD?: (NEVER/OCCASIONALLY/ALWAYS?): \_\_\_\_\_

DID THIS PATIENT REQUIRE BEING HELD IN A SPECIAL MANNER?: \_\_\_\_\_  
IF SO, WHAT DID/DID NOT WORK?: \_\_\_\_\_

PLEASE DESCRIBE THIS PATIENT'S PERSONALITY DURING THE FIRST 12 MONTHS: (BY  
MOTHER/OTHER OBSERVORS-PLEASE IDENTIFY BY WHOM): \_\_\_\_\_

DID THIS PATIENT GO THROUGH A PERIOD EARLY ON WHEN IF YOU (PRIMARY  
CARETAKER) WERE HOLDING THE PATIENT, HE/SHE WOULD BE FINE, HOWEVER IF YOU  
WOULD HAND THE PATIENT TO ANYONE ELSE, HE/SHE WOULD BECOME FRETFUL, UPSET,  
AND/OR CRY?: \_\_\_\_\_ IF SO, AT WHAT AGE?: \_\_\_\_\_ AT WHAT AGE DID  
THIS PATIENT FIRST SIT ALONE?: \_\_\_\_\_ STAND?: \_\_\_\_\_  
WALK ALONE?: \_\_\_\_\_ USE SINGLE WORDS (OTHER THAN MAMA OR  
DADA)? \_\_\_\_\_ USE SHORT SENTENCES?: \_\_\_\_\_

DID THIS PATIENT GO THROUGH A PERIOD EARLY ON WHEN YOU (PRIMARY CARETAKER)  
NOTICED HE/SHE BECAME STUBBORN/HARD HEADED/NEGATIVISTIC/OR OPPOSITIONAL?:  
\_\_\_\_\_ IF SO, PLEASE GIVE AGE OF ONSET/RESOLUTION: \_\_\_\_\_  
HOW OLD WAS THIS PATIENT WHEN HE/SHE FIRST SPENT TIME AWAY FROM HOME ON A  
REGULAR BASIS (e.g.: DAILY/WEEKLY) WITH SOMEONE THAT HE/SHE DID NOT KNOW?:  
(e.g.: DAY CARE/NURSERY SCHOOL/PRESCHOOL/OR KINDERGARTEN)? \_\_\_\_\_

WHAT WERE THE DESCRIPTIONS (ADJECTIVES USED) OF THIS PATIENT GIVEN TO YOU BY  
THESE CHILD CARE WORKERS?: \_\_\_\_\_

HAVE YOU OR ANYONE EXPRESSED CONCERN THAT THIS PATIENT MAY HAVE PROBLEMS  
WITH CONCENTRATION?: \_\_\_\_\_ IF SO, WHO?: \_\_\_\_\_  
DOES THIS PATIENT HAVE PROBLEMS WITH: SELF ESTEEM?: \_\_\_\_\_  
IMPULSIVE BEHAVIOR?: \_\_\_\_\_ SENSITIVITY TO SLIGHTS?: \_\_\_\_\_  
KEEPING/MAKING FRIENDS?: \_\_\_\_\_ FRUSTRATION TOLERANCE?: \_\_\_\_\_  
RESTLESSNESS/DIFFICULTY SITTING STILL?: \_\_\_\_\_  
DIFFICULTY WITH CHANGES?: \_\_\_\_\_  
DIFFICULTY COMPLETING TASKS?: \_\_\_\_\_  
DIFFICULTY WITH ATTENTION?: \_\_\_\_\_ CONCENTRATION?: \_\_\_\_\_  
BREATH HOLDING?: \_\_\_\_\_ TEETH GRINDING?: \_\_\_\_\_  
THUMB SUCKING OR OTHER IMMATURE BEHAVIORS?: \_\_\_\_\_

KNOWN OR SUSPECTED SEXUAL ACTING OUT?: \_\_\_\_\_  
MASTURBATION/INAPPROPRIATE SEXUAL BEHAVIOR?: \_\_\_\_\_  
BEHAVIOR PROBLEMS?: \_\_\_\_\_

REPETITIVE BEHAVIORS?: \_\_\_\_\_  
LEARNING PROBLEMS?: \_\_\_\_\_  
DIFFICULTY UNDERSTANDING THE DIFFERENCE BETWEEN REAL AND PRETEND?: \_\_\_\_\_

UNUSUAL OR EXCESSIVE INTEREST IN FANTASY/PRETEND IDEAS?: \_\_\_\_\_

DIFFICULTY FOLLOWING PARENTAL/ADULT REQUESTS?: \_\_\_\_\_

STEALING?: \_\_\_\_\_ LYING?: \_\_\_\_\_

UNUSUAL PREOCCUPATIONS?: \_\_\_\_\_

DIFFICULTY IN MAKING OR KEEPING FRIENDS?: \_\_\_\_\_

PREFERENCE FOR YOUNGER OR OLDER FRIENDS?: \_\_\_\_\_

MANNER OF RELATING TO FAMILY MEMBERS: PARENTS?: \_\_\_\_\_

BROTHERS OR SISTERS?: \_\_\_\_\_

ABSENCE OF REMORSE AFTER WRONG DOING?: \_\_\_\_\_

KNOWN OR SUSPECTED ALCOHOL/DRUG/OR TOBACCO USE?: \_\_\_\_\_

SPEECH PROBLEMS?: \_\_\_\_\_

REPETITIVE SPEECH (WORDS, PHRASES, AND/OR SOUNDS)?: \_\_\_\_\_

UNUSUAL USE OF WORDS, PHRASES, OR SOUNDS?: \_\_\_\_\_

LETTER OR NUMBER REVERSALS?: \_\_\_\_\_

DIFFICULTY WITH PHYSICAL COORDINATION/AKWARDNESS?: \_\_\_\_\_

UNUSUAL/ADVANCED ABILITIES?: \_\_\_\_\_

DIFFICULTY WAITING HIS/HER TURN?: \_\_\_\_\_

DISRUPTING CLASSROOM ACTIVITIES?: \_\_\_\_\_

DIFFICULTY ORGANIZING TIME/TASKS/OR POSSESSIONS?: \_\_\_\_\_

IMPULSIVE BEHAVIORS?: \_\_\_\_\_

ABSENCE OF CONCERN FOR CONSEQUENCES FOR BEHAVIORS?: \_\_\_\_\_

ABSENCE OF AWARENESS FOR HIS/HER/OTHER'S SAFETY?: \_\_\_\_\_

DESTRUCTION OF HIS/HER OR OTHER'S PROPERTY?: \_\_\_\_\_

THREATS OF OR ACTUAL RUNAWAY BEHAVIOR?: \_\_\_\_\_

DOES THIS PATIENT EVER SPEND TIME WITH PEOPLE/PEERS NOT APPROVED BY PARENT/GUARDIAN?: \_\_\_\_\_

DOES THIS PATIENT EVER REFUSE TO COOPERATE WITH PARENTS/ADULTS?: \_\_\_\_\_

PROBLEMS SKIPPING CLASS OR SCHOOL?: \_\_\_\_\_

PROBLEMS WITH SCHOOL SUSPENSION OR EXPULSION?: \_\_\_\_\_

ANY PRIOR OR CURRENT INVOLVEMENT WITH JUVENILE COURT?: \_\_\_\_\_

IF SO, LIST AGES(S)/DATES/WHAT COURT ACTION?: \_\_\_\_\_

IS THIS PATIENT CURRENTLY UNDER JUVENILE COURT PROBATION/SUPERVISION?: \_\_\_\_\_

DATES/LENGTH OF PROBATION?: \_\_\_\_\_

PROBATION OFFICER'S NAME/COUNTY OF COURT?: \_\_\_\_\_

PROBATION OFFICER'S CONTACT PHONE NUMBER?: \_\_\_\_\_

FIGHTING?: \_\_\_\_\_ USE OF A WEAPON IN FIGHTING?: \_\_\_\_\_

IF SO, WHAT WEAPONS?: \_\_\_\_\_

INITIATES FIGHTS?: \_\_\_\_\_ DIFFICULTY STANDING UP FOR SELF?: \_\_\_\_\_

ARGUES WITH ADULTS/AUTHORITY FIGURES?: \_\_\_\_\_

PHYSICAL AGGRESSION TOWARD OTHERS/ADULTS?: \_\_\_\_\_  
PROBLEMS WITH AVOIDING OR MANIPULATING RULES?: \_\_\_\_\_  
PROBLEMS WITH AWARENESS OR REGARD FOR OTHER'S FEELINGS?: \_\_\_\_\_

BLAMING OF OTHERS FOR HIS/HER MISTAKES?: \_\_\_\_\_  
UNNECESSARY WORRY ABOUT PARENT/OTHERS SAFETY OR WELLBEING?: \_\_\_\_\_

UNUSUAL INTEREST IN DEATH OR DYING?: \_\_\_\_\_  
STATEMENTS ABOUT/CONCERNING SUICIDE?: \_\_\_\_\_  
STATEMENTS ABOUT/CONCERNING HOMICIDE?: \_\_\_\_\_  
REFUSAL TO ATTEND SCHOOL?: \_\_\_\_\_  
REFUSAL TO GO TO SLEEP WITHOUT SOMEONE NEARBY?: \_\_\_\_\_  
REFUSAL/RESISTANCE IN SPENDING A NIGHT AWAY FROM HOME?: \_\_\_\_\_  
AVOIDANCE OF BEING ALONE?: \_\_\_\_\_  
NIGHTMARES?: \_\_\_\_\_

UNUSUAL INTEREST IN PARENT/ADULT ISSUES (e.g.: PARENT FINANCES, PHYSICAL HEALTH, OR MARITAL ISSUES)?: \_\_\_\_\_  
UNUSUAL SELF-CONSCIOUSNESS?: \_\_\_\_\_  
UNUSUAL NEED FOR REASSURANCE?: \_\_\_\_\_  
UNUSUAL INTEREST/CONCERN ABOUT: PATIENT'S OWN BODY SIZE?: \_\_\_\_\_  
WEIGHT GAIN/LOSS?: \_\_\_\_\_  
SUSPECTED/KNOWN BINGE EATING?: \_\_\_\_\_  
SELF INDUCED VOMITING?: \_\_\_\_\_  
PRIOR WEIGHT CHANGE?: \_\_\_\_\_  
PATIENT'S USE OF STRICT DIETING?: \_\_\_\_\_  
PATIENT'S USE OF LAXATIVES?: \_\_\_\_\_  
PATIENT'S USE OF DIURETICS/WATER PILLS?: \_\_\_\_\_  
FAILURE TO GAIN WEIGHT/GROW AS EXPECTED?: \_\_\_\_\_  
UNUSUAL CONCERN ABOUT BEING MALE OR FEMALE?: \_\_\_\_\_  
EXPRESSED DESIRE TO BE THE OPPOSITE SEX?: \_\_\_\_\_  
OBSERVED CHARACTERISTICS MORE COMMON TO THE OPPOSITE SEX?: \_\_\_\_\_

WEARING OF CLOTHING MORE CHARACTERISTIC OF THE OPPOSITE SEX?: \_\_\_\_\_

PURSUIT OF INTERESTS MORE CHARACTERISTIC OF THE OPPOSITE SEX?: \_\_\_\_\_

PUBERTY ONSET: FEMALES: FIRST PERIOD: (AGE): \_\_\_\_\_ LAST PERIOD?: (AGE): \_\_\_\_\_  
BREAST ENLARGEMENT?: (AGE): \_\_\_\_\_ AXILLARY HAIR (AGE)?: \_\_\_\_\_  
GROWTH SPURT?: (AGE): \_\_\_\_\_ MALES: (AXILLARY HAIR/GROWTH SPURT/  
FACIAL HAIR)?: \_\_\_\_\_  
PRESENCE OF SPEECH/MOTOR OR OTHER TICS?: \_\_\_\_\_

STUTTERING?: \_\_\_\_\_ REFUSAL TO SPEAK?: \_\_\_\_\_  
RAMBLING OR INCOHERENT SPEECH?: \_\_\_\_\_  
PROBLEMS WITH MEMORY?: \_\_\_\_\_  
BELIEF IN UNREALISTIC IDEAS?: \_\_\_\_\_  
REPORTS OF SEEING OR HEARING IMAGINARY THINGS?: \_\_\_\_\_

REPORTS OF/OBSERVATIONS OF DEPRESSION OR SADNESS?: \_\_\_\_\_

OBSERVED OR REPORTED MOOD SWINGS?: \_\_\_\_\_

WITHDRAWAL OR ISOLATION FROM OTHER PEOPLE?: \_\_\_\_\_

PROBLEMS WITH KNOWING HIS/HER NAME?: \_\_\_\_\_ DATE/AGE?: \_\_\_\_\_

PROBLEMS WITH KNOWING HIS/HER GEOGRAPHIC LOCATION?: \_\_\_\_\_

PARENT/GUARDIAN'S ESTIMATE OF PATIENT'S INTELLECTUAL ABILITY?: \_\_\_\_\_

WHAT PERCENTAGE OF THIS PATIENT'S INTELLECTUAL ABILITY IS THIS PATIENT USING?:

OVERALL?: \_\_\_\_\_ IN SCHOOL?: \_\_\_\_\_ AT HOME?: \_\_\_\_\_

AT PLAY OR WITH PEERS/FRIENDS?: \_\_\_\_\_ IF THIS PATIENT IS NOT PERFORMING

UP TO THEIR ABILITY, WHAT DOES THIS PATIENT NEED TO DO TO IMPROVE?: \_\_\_\_\_

HAS THIS PATIENT HAD UNREALISTIC FEARS?: \_\_\_\_\_ IF SO, PLEASE LIST: \_\_\_\_\_

HAS THIS PATIENT HAD PROBLEMS SHARING?: \_\_\_\_\_

DOES THIS PATIENT EXHIBIT PROBLEMS WITH: UNUSUAL COMPETITIVENESS: \_\_\_\_\_

JEALOUSY?: \_\_\_\_\_ IF SO, PLEASE DESCRIBE THE TYPE OF SITUATION OR

SETTING THESE ATTITUDES ARE OBSERVED?: \_\_\_\_\_

REPORTS OF/OBSERVATIONS OF FATIGUE?: \_\_\_\_\_

REPORTS OF/OBSERVATIONS OF POOR SELF ESTEEM?: \_\_\_\_\_

POOR IMPULSE CONTROL?: \_\_\_\_\_

REPORTS OF/OBSERVATIONS OF FEELINGS OF WORTHLESSNESS?: \_\_\_\_\_

REPORTS OF/OBSERVATIONS OF UNUSUAL FEELINGS OF GUILT?: \_\_\_\_\_

REPORTS OF/OBSERVATIONS OF NERVOUSNESS OR ANXIETY?: \_\_\_\_\_

DO EVENTS OR CIRCUMSTANCES SEEM TO MARKEDLY ALTER THIS PATIENT'S MOOD?: \_\_\_

DOES THIS PATIENT HAVE PERIODS OF EASY IRRITABILITY?: \_\_\_\_\_

IF SO, DESCRIBE STRESSES AND QUALITY OF MOODS PRODUCED?: \_\_\_\_\_

HAS THIS PATIENT DESCRIBED RECURRENT OR PERSISTENT UNUSUAL THOUGHTS?: \_\_\_\_\_

IF SO, PLEASE DESCRIBE: \_\_\_\_\_

PLEASE LIST BY TYPE AND DATE ANY UNUSUAL LIFE STRESSES THIS PATIENT HAS EXPERIENCED (e.g.: DEATH OF A PARENT, AGE 6): \_\_\_\_\_

DIFFICULTY FALLING/STAYING ASLEEP?: \_\_\_\_\_

EARLY MORNING AWAKENING?: \_\_\_\_\_

DOES THIS PATIENT RESIST: GOING TO BED?: \_\_\_\_\_ SLEEPING ALONE?: \_\_\_\_\_  
IF SO, PLEASE DESCRIBE WHAT CIRCUMSTANCES ARE NECESSARY FOR THE PATIENT TO  
GO TO SLEEP?: \_\_\_\_\_

DOES THIS PATIENT RESIST OR COOPERATE WITH MEDICATION WHEN PRESCRIBED?: \_\_\_\_\_

HAS THIS PATIENT HAD AN IMAGINARY FRIEND?: \_\_\_\_\_ IF SO, AT WHAT AGE &  
FOR HOW LONG?: \_\_\_\_\_

WHAT ARE THIS PATIENT'S FAVORITE GAMES/ACTIVITIES?: \_\_\_\_\_

DOES THIS PATIENT PRETEND TO BE IMAGINARY OR OTHER PEOPLE?: \_\_\_\_\_  
IF SO, PLEASE DESCRIBE:?

HAS THIS PATIENT EVER DESCRIBED UNUSUAL EXPERIENCES?: \_\_\_\_\_ IF SO, PLEASE  
DESCRIBE: \_\_\_\_\_

DOES THIS PATIENT EVER DO OR SAY THINGS WHICH THE PARENT OR GUARDIAN DOES  
NOT UNDERSTAND OR THAT DOES NOT MAKE SENSE?: \_\_\_\_\_ IF SO, PLEASE DESCRIBE:

HAS THIS PATIENT EVER SLEEP WALKED?: \_\_\_\_\_ IF SO, PLEASE DESCRIBE THE  
NATURE AND AGE(S): \_\_\_\_\_

HAS THIS PATIENT EVER ATTEMPTED TO KILL HIS/HER SELF?: \_\_\_\_\_ IF SO, PLEASE  
LIST AND DESCRIBE EACH EVENT AND AGE(S): \_\_\_\_\_

HAS THIS PATIENT EVER DESCRIBED THOUGHTS OR PLANS OF HOW HE/SHE MIGHT TRY  
TO HURT THEMSELVES OR OTHERS?: \_\_\_\_\_ IF SO, PLEASE DESCRIBE IN DETAIL EACH  
PLAN AND THE PATIENT'S AGE(S): \_\_\_\_\_

DOES THIS PATIENT HAVE PROBLEMS WITH ATTENTION SEEKING BEHAVIORS?: \_\_\_\_\_  
IF SO, PLEASE DESCRIBE: \_\_\_\_\_

HAS THIS PATIENT EXHIBITED OVER CONCERN FOR HIS/HER PHYSICAL  
ATTRACTIVENESS?: \_\_\_\_\_ IF SO, PLEASE DESCRIBE: \_\_\_\_\_

HAS THIS PATIENT EVER DESCRIBED/REPORTED THAT ANOTHER PERSON HAS TOUCHED  
THEM IN THEIR PRIVATES OR IN A WAY THAT MADE THEM UNCOMFORTABLE?: \_\_\_\_\_  
IF SO, PLEASE DESCRIBE EVENTS AND PATIENT'S AGE(S): \_\_\_\_\_



PLEASE LIST ANY KNOWN FAMILY HISTORY OF PHYSICAL/MEDICAL PROBLEMS: (INCLUDE FAMILY MEMBERS RELATIONSHIP TO PATIENT, AGE, NATURE OF ILLNESS AND ANY TREATMEN WHICH WAS REQUIRED): \_\_\_\_\_

HAS ANY MEMBER OF THE FAMILY EVER BEEN INCARCERATED?: \_\_\_\_\_ IF SO, PLEASE INDICATE WHICH FAMILY MEMBER AND THE NATURE, REASON (INCLUDING TOTAL LENGTH OF INCARCERATION) FOR THE INCARCERATION: \_\_\_\_\_

PLEASE LIST ANY PRIOR MEDICATIONS THIS PATIENT HAS TAKEN INCLUDING ANY SIDE EFFECTS/REACTIONS: \_\_\_\_\_

IS THIS PATIENT CURRENTLY UNDER THE CARE OF A PEDIATRICIAN OR FAMILY PHYSICIAN?: \_\_\_\_\_ IF SO, PLEASE PROVIDE THE PHYSICIAN'S NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_ PLEASE LIST ANY MEDICAL PROBLEMS FOR WHICH THIS PATIENT IS CURRENTLY BEING TREATED: \_\_\_\_\_

PLEASE LIST ANY PRIOR HOSPITALIZATIONS THIS PATIENT HAS REQUIRED INCLUDING THE NATURE OF THE PROBLEM AND AGE(S): \_\_\_\_\_

PLEASE LIST ANY PRIOR SURGERY THIS PATIENT HAS REQUIRED INCLUDING TYPE/ REASON FOR SURGERY AND PATIENT'S AGE(S): \_\_\_\_\_

PLEASE LIST ANY ILLNESSES FOR WHICH OTHER FAMILY MEMBERS ARE CURRENTLY BEING TREATED (INCLUDING TYPE OF TREATMENT AND/OR MEDICATIONS): \_\_\_\_\_

PLEASE LIST ANY HOSPITALIZATIONS/SURGERIES THAT OTHER FAMILY MEMBERS HAVE REQUIRED BY FAMILY MEMBER, NATURE OF ILLNESS AND/OR SURGERY AND AGE(S): \_\_\_\_\_

(CONT'D): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ANY CURRENT MEDICATIONS THIS PATIENT IS TAKING INCLUDING DOSEAGE(S): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HAS THIS PATIENT EVER HAD (PLEASE GIVE AGE)?: MUMPS: \_\_\_\_\_  
MEASELS: \_\_\_\_\_ CHICKEN POX: \_\_\_\_\_ POLIO: \_\_\_\_\_  
WHOOPING COUGH: \_\_\_\_\_ HEPATITIS: \_\_\_\_\_  
HIGH FEVERS: \_\_\_\_\_ SEIZURES: \_\_\_\_\_  
HEADACHES: \_\_\_\_\_ DIZZINESS: \_\_\_\_\_  
LOSS OF CONSCIOUSNESS: \_\_\_\_\_ HEAD TRAUMA: \_\_\_\_\_  
BLURRED VISION: \_\_\_\_\_ MENINGITIS: \_\_\_\_\_  
BIRTH DEFECT: \_\_\_\_\_ RECURRENT EAR INFECTIONS: \_\_\_\_\_  
EAR TUBES: \_\_\_\_\_ RECURRENT SORE THROATS, SINUSITIS, UPPER  
RESPIRATORY INFECTIONS, STREP THROAT, BRONCHITIS, OR ASTHMATIC ATTACKS? \_\_\_\_\_  
IF SO, PLEASE INDICATE SPECIFIC ILLNESSES AND AGE(S): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

THYROID PROBLEMS?: \_\_\_\_\_ ALLERGIES?: \_\_\_\_\_  
HEART MURMUR?: \_\_\_\_\_ OTHER HEART PROBLEMS (PLEASE  
DESCRIBE): \_\_\_\_\_  
\_\_\_\_\_

RECURRENT ABDOMINAL PAIN?: \_\_\_\_\_  
DIARRHEA?: \_\_\_\_\_ CONSTIPATION?: \_\_\_\_\_  
BLOODY STOOLS?: \_\_\_\_\_ VOMITING?: \_\_\_\_\_  
FOOD INTOLERANCE?: \_\_\_\_\_ SPECIAL DIETARY REQUIREMENTS?: \_\_\_\_\_  
\_\_\_\_\_

URINARY TRACT INFECTIONS?: \_\_\_\_\_  
SUSPECTED/KNOWN SEXUAL ACTIVITY?: \_\_\_\_\_  
USE OF BIRTH CONTROL?: \_\_\_\_\_  
FEMALES?: LAST MENSTRUAL PERIOD?: \_\_\_\_\_ REGULAR?: \_\_\_\_\_  
CYCLIC LENGTH?: \_\_\_\_\_ PREVIOUS FRACTURES (PLEASE GIVE BONE,  
PATIENT AGE(S), AND TYPE OF TREATMENT REQUIRED: \_\_\_\_\_  
\_\_\_\_\_

SKIN PROBLEMS?: \_\_\_\_\_  
BLEEDING/BLOOD PROBLEMS?: \_\_\_\_\_  
HAS ANYONE IN THIS PATIENT'S FAMILY EVER HAD: NERVE PROBLEMS?: \_\_\_\_\_  
(CONT'D)

SEIZURES: \_\_\_\_\_ BLOOD/BLEEDING PROBLEMS: \_\_\_\_\_  
 THYROID PROBLEMS: \_\_\_\_\_ HIGH BLOOD PRESSURE: \_\_\_\_\_  
 DIABETES: \_\_\_\_\_ HIGH/ABNORMAL CHOLESTEROL: \_\_\_\_\_  
 OR TRIGLYCERIDES: \_\_\_\_\_ CYSTIC FIBROSIS: \_\_\_\_\_  
 KIDNEY DISEASE: \_\_\_\_\_ ASTHMA: \_\_\_\_\_  
 ALLERGY: \_\_\_\_\_ HEART DISEASE: \_\_\_\_\_  
 BIRTH DEFECTS: \_\_\_\_\_ CANCER: \_\_\_\_\_  
 OTHER: \_\_\_\_\_ IS THIS PATIENT RIGHT/LEFT HANDED: \_\_\_\_\_  
 PHYSICAL COMPLAINTS: \_\_\_\_\_  
 HEARING PROBLEMS: \_\_\_\_\_  
 VISION PROBLEMS: \_\_\_\_\_  
 WHEN WAS THIS PATIENT'S LAST PHYSICAL EXAM?: \_\_\_\_\_  
 NAME OF PHYSICIAN?: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 WHEN WAS THIS PATIENT'S LAST EVALUATION OF: HEARING?: \_\_\_\_\_  
 VISION?: \_\_\_\_\_ PLEASE LIST ANY KNOWN PATIENT ALLERGIES  
 (INCLUDE MEDICATIONS): \_\_\_\_\_

DATE/TYPE	OF	PATIENT'S	LAST	IMMUNIZATIONS(S):

ARE THIS PATIENT'S IMMUNIZATIONS CURRENT?: \_\_\_\_\_ (PLEASE PROVIDE A COPY OF THIS PATIENT'S IMMUNIZATION RECORD)  
 PLEASE LIST ANY CONCERNS NOT ADDRESSED IN THIS QUESTIONNAIRE: \_\_\_\_\_

PLEASE LIST DISCIPLINE TECHNIQUES THAT "WORK": \_\_\_\_\_

PLEASE LIST DISCIPLINE TECHNIQUES THAT "DO NOT WORK": \_\_\_\_\_

THIS QUESTIONNAIRE WAS COMPLETED BY: \_\_\_\_\_  
 RELATIONSHIP TO PATIENT: \_\_\_\_\_

\_\_\_\_\_  
 SIGNATURE

\_\_\_\_\_  
 PLEASE PRINT/TYPE NAME

\_\_\_\_\_  
 DATE

