



Patient History Form Austin Diagnostic Clinic- Pediatrics

Date _____
Child's Name _____ Birth Date _____ M F
Address _____
Child's School _____
Grade Level _____ Teacher's Name _____
Briefly state the main problem of this child _____

May we have permission to contact your child's teacher or other school personnel concerning his/her school performance and any records that pertain to this problem? Y N
If yes, sign and date here _____

PARENTS

Mother _____ Birth Date _____
Address _____
Phone Home _____ Work _____ Cell _____ Occupation _____
Age at the time of pregnancy with patient _____
Education: Highest grade completed _____
 Learning problems? _____
 Attention problems? _____
 Behavior problems? _____

Any medical problems? _____
Have any of your blood relatives experienced problems similar to those your child is experiencing? If so, describe: _____

Father _____ Birth Date _____
Address _____
Phone Home _____ Work _____ Cell _____ Occupation _____
Age at the time of pregnancy with patient _____
Education: Highest grade completed _____
 Learning problems? _____
 Attention problems? _____
 Behavior problems? _____

Any medical problems? _____
Have any of your blood relatives experienced problems similar to those your child is experiencing? If so, describe: _____

Child is presently living with:

____ Natural Mother ____ Natural Father ____ Step Mother
____ Adoptive Mother ____ Adoptive Father ____ Step Father
____ Foster Mother ____ Foster Father
____ Other (Specify) _____

SIBLINGS

	Name	Age	Medical, social or school problems
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

FAMILY HISTORY

Is there any family history of abuse, alcoholism, allergy/asthma, anemia/bleeding problems, anxiety disorders, birth defects/mental retardation, criminal activity, cystic fibrosis, deafness, depression, diabetes, drug addiction, emotional disorders, heart attack/high blood pressure, hypo/hyperthyroidism, kidney/liver disease, seizures/epilepsy, neurofibromatosis, tics, tuberous sclerosis, or tuberculosis? **If so, circle those known to be present.**

Have any young family member ever died from a cardiac-related issue? Y N

PREGNANCY

List any problems with pregnancy (infections, bleeding, high blood pressure, toxemia, injuries) _____

Smoking during pregnancy? _____ # of cigarettes a day _____

Alcohol consumption during pregnancy _____

Medications taken during pregnancy (legal/illegal, prescription or over the counter) _____

DELIVERY

How long was labor? _____ Spontaneous? _____ Induced? _____

Type of delivery: Vaginal _____ Cesarean _____ Breech _____

Any complications of delivery? _____

Any problems for mom or baby after birth? _____

Child's birth weight _____ Number of days in hospital _____

Was child premature? Y N If so, how early? _____

INFANCY PERIOD (first year of life)

Was child "colicky"? Y N Difficult to comfort? Y N

Enjoy cuddling? Y N Have any sleep problems? Y N

Excessively irritable? Y N Constantly into everything? Y N

TEMPERMENT

Please rate the following behaviors as your child appeared **while he was an infant or toddler.**

ACTIVITY LEVEL – How active was your child from an early age? _____

DISTRACTIBILITY – How well did your child pay attention? _____

ADAPTABILITY – How well did you child deal with transition and change? _____

APPROACH/WITHDRAWAL – How well did your child respond to new things (i.e., places, people, food, etc.) ? _____

INTENSITY – Whether happy or unhappy, how aware are others of your child’s feelings? _____

MOOD – What was your child’s basic mood? _____

REGULARITY – How predictable was your child in patterns of sleep, appetite, etc.? _____

MEDICAL HISTORY

List any hospitalizations and causes _____

Any recurrent illnesses? _____

Any head injury with loss of consciousness? _____

Any broken bones or other serious injuries? _____

Any chronic illnesses (ie. asthma, diabetes, heart condition)? _____

Any food, drug or inhalant allergies, known or suspected? _____

Circle all illnesses your child has had - Mumps Measles Chickenpox
Scarlet Fever Meningitis Encephalitis Reye’s Syndrome Lead Poisoning
Pneumonia Vision Problems Hearing Problems

Has your child had any seizures or tics (ie, involuntary eye blinking, sniffing, staring spells or any other repetitive, non-purposeful movement)? _____

Any problems with bed wetting? _____

Any problems with stooling in pants? _____

Any sleep disturbances or trouble getting to sleep? _____

Describe your child’s appetite. _____

Has your child had vision and hearing checked ?_____ If so, when, where, and what were the results? _____

Circle any of the following problems your child has had. Fainting Structural heart defect Weight loss Constipation Tremors of the hands or fingers Sluggishness
Excessive appetite Excessive sweating Racing of the heart Excessive sleepiness

Do you have any suspicion of drug or alcohol abuse in your child? _____

Any history of physical or sexual abuse? _____

Has your child received any testing or counseling through school or any other facility?
Y N If so, where? _____
Does your child live in or regularly visit a home or other location built before 1960 with
chipping or peeling paint or that has been recently remodeled? _____
Does your child have any relatives or friends that have been diagnosed with lead
poisoning? _____
Does your child live with anyone whose job or hobby involves exposure to lead (such as
painting, soldering, auto battery manufacturing or recycling or auto body repair)? _____
Does your child live near an active lead smelter, battery recycling plant or other industry
likely to release lead? _____
Does your family frequently eat off of Mexican clay cookware or pottery? _____

PRESENT MEDICAL STATUS

Is your child presently being treated for any illness? Y N If so, please list illnesses.

Is your child presently taking any medications? Y N If so, please list them. _____

DEVELOPMENT

Did your child accomplish the tasks listed below at the same time other children
accomplished them? Y N If not, at what age did he accomplish them?

Walking _____ Spoke first words _____
Speaking in sentences _____ Speech easily understood _____
Bladder and bowel trained _____ Rode tricycle _____
Rode bicycle without training wheels _____
Buttoned clothing _____ Tied shoelaces _____
Named colors _____ Began to read _____

Compared to other children, how would you rate your child's intelligence?
Average Below Average Above Average

SCHOOL HISTORY

Did your child attend day care or preschool prior to kindergarten? Y N
If yes, were there any concerns about behaviors? _____

Were you concerned in any way about your child's ability to succeed in pre-school or
kindergarten? Y N If so, please explain: _____

Have any teachers ever mentioned concerns about your child's school behaviors? Y N
If so, please describe their concerns: _____

Has your child ever repeated or skipped a grade? Y N If so, which one(s)? _____

Have you ever had a group meeting at school about your child that included the parents, teachers, counselor, and principal? Y N

Has your child ever been included in any extra educational assistance like:

Classes for learning disability Y N Which subject(s)? _____

Utilized resource room Y N

Speech and language therapy Y N

Special education class Y N

Behavioral/emotional disorder class Y N

Received help in Content Mastery Room Y N

Tutoring Y N In school? _____ Outside of school? _____

To the best of your knowledge, at what grade level is your child functioning in these subjects: Reading _____ Spelling _____ Math _____

In the classroom what changes have been made to help your child achieve academically and behaviorally? _____

PEER RELATIONSHIPS

Does your child make friends easily? Y N

How well does he get along with friends? _____

Is he sought by peers for friendship? Y N

He prefers to play primarily with children - His own age ____ Younger ____ Older ____

HOME ISSUES

How does this child get along with brothers/sisters? _____

What techniques have been used at home to assist this child with school concerns and/or behavioral concerns? _____

Check any of these stressful events below that have happened to your child. Please indicate the year of the occurrence.

	<u>Year</u>
Parents divorced or separated _____	_____
Serious family accident or illness _____	_____
Death in the family _____	_____
Parent changed job _____	_____
Changed school _____	_____
Family moved _____	_____
Family financial problems _____	_____
Chronic illness of a family member _____	_____

BEHAVIORAL CONCERNS

Check any of the following behaviors that are considered to be significant problems:

Fidgets _____ Leaves seat inappropriately _____ Cannot play quietly _____
Is "always on the go" _____ Talks excessively _____ Blurts out answers _____
Can't wait in line _____ Interrupts or intrudes on others _____ Doesn't listen _____
Makes careless mistakes _____ Can't pay attention to tasks _____ Loses things _____
Fails to finish schoolwork _____ Problems with organization _____ Avoids tasks taking
much attention _____ Is easily distracted _____ Is forgetful in daily activities _____

At what age did you first notice these behaviors? _____

Check any of the following behaviors that are considered to be significant problems:

Often loses temper _____ Often argues with adults _____ Actively defies or refuses adult
requests or rules _____ Often deliberately does things that annoy others _____ Often
blames others for his own mistakes _____ Is often angry or resentful _____ Is often
touchy or easily annoyed by others _____ Is often spiteful or vindictive _____ Often
swears or uses obscene language _____

At what age did you first notice these behaviors? _____

Check any of the following behaviors that are considered to be significant problems:

Stolen others things _____ Run away from home _____ Lies often _____ Deliberate fire
setting _____ Truant _____ Destroying others property _____ Cruel to animals _____
Initiates fights _____ Physically cruel to people _____

At what age did you first notice these behaviors? _____

Check any of the following behaviors that are considered to be significant problems:

Unrealistic and persistent worry about possible harm to attachment figures _____
Persistent refusal to attend school _____ Persistent refusal to sleep alone _____
Persistent avoidance of being alone _____ Repeated nightmares _____ Many physical
complaints _____ Much distress in separating from attachment figures _____

At what age did you first notice these behaviors? _____

Check any of the following behaviors that are considered to be significant problems:

Unrealistic worry about future events _____ Unrealistic concern about inappropriate past
behaviors _____ Unrealistic concern about abilities to accomplish a task _____ Excessive
need for reassurance _____ Marked self-consciousness _____

At what age did you first notice these behaviors? _____

Check any of the following behaviors that are considered to be significant problems:

Irritable or depressed mood most of the day, nearly every day _____ Diminished pleasure in activities _____ Poor appetite or over eating _____ Poor concentration or difficulty making decisions _____ Unable to get to sleep or sleeps a lot more than others nearly every day _____ Complains of fatigue or loss of energy _____ Feelings of worthlessness or excessive inappropriate guilt _____ Talk of suicide _____

At what age did you first notice these behaviors? _____

INTERESTS AND ACCOMPLISHMENTS

What are your child's main interests and hobbies? _____

What does your child enjoy doing most? _____

What does your child dislike doing most? _____

What do you like about your child? _____

Thank you for taking the time to complete this history form. Mail or bring this form to the office along with the completed questionnaires from teachers and family. We will call you to set up an appointment to go over all the information. We look forward to working with your family to help your child meet his potential in school.