Child & Family Information Form

Today's Date: ____ / ____ / ____

Patient Name: ______________________________ Date of Birth: ____/____/____

Name of person completing form: ______________ Relationship to patient: ❑ Parent ❑ Guardian ❑ Other: __________

Current school: ______________________________ Grade: ______

Teacher(s): ______________________________

Family Information

Please answer the following questions about each adult who is involved in parenting your child, including stepparents, if applicable.

Name: ______________________________

Age: _____ Education/Highest Grade Completed: ______

Occupation: ______________________________

Employer: ______________ Years Employed: _____

Name: ______________________________

Age: _____ Education/Highest Grade Completed: ______

Occupation: ______________________________

Employer: ______________ Years Employed: _____

Name: ______________________________

Age: _____ Education/Highest Grade Completed: ______

Occupation: ______________________________

Employer: ______________ Years Employed: _____

Please list all children in the family/household.

Name: ______________________________

Age: _____ School Grade/Occupation: __________

Name: ______________________________

Age: _____ School Grade/Occupation: __________

Name: ______________________________

Age: _____ School Grade/Occupation: __________

Name: ______________________________

Age: _____ School Grade/Occupation: __________

Name: ______________________________

Age: _____ School Grade/Occupation: __________

About Your Child

1. Please tell us a bit about the specific behaviors/difficulties that you are concerned about:

2. When did you start to have these concerns?

3. Are there any specific factors that you think may be causing or adding to your child's difficulties?

4. Please list your child's strengths—what do you admire about your child?

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5. What skills/abilities would you like to see your child develop?

6. Has your child had any previous evaluations for these difficulties inside or outside of school? ❑ Yes ❑ No

If yes, where and when?

7. Has your child ever received any type of mental/behavioral health treatment? ❑ Yes ❑ No

If yes, where and when?

8. Has your child ever been prescribed medication for mood or behavioral concerns? ❑ Yes ❑ No

If yes, where, when, what, and how much?

9. Has your child ever had any of the following concerns?

Concern	Yes	No	If yes, please explain and provide age range.
• Colic	❑	❑	
• Feeding or eating problems	❑	❑	
• Problem with growth (height and/or weight)	❑	❑	
• Bedwetting (beyond 5 years old)	❑	❑	
• Other problems with bladder or bowel control	❑	❑	
• Tantrums (more than other children of same age)	❑	❑	
• Unwillingness to change daily	❑	❑	
• A time when your child had a greatly decreased need for sleep	❑	❑	
• A time when your child's thoughts seemed to be racing	❑	❑	
• Has your child ever been diagnosed by a professional with a mental/behavioral health diagnosis or developmental disability?	❑	❑	If yes, check all that apply: ❑ ADD or ADHD ❑ Depression ❑ Anxiety ❑ Behavior problems ❑ Learning disability ❑ Developmental disability ❑ Trauma
• Has your child had any unusual and/or traumatic family events that you feel may have impacted his/her development and current concerns? Such stressors might include the birth or death of a sibling, any death in the family, divorce, illness in the family, frequent moves and/or school changes, domestic violence or otherwise conflictual family dynamics, etc.	❑	❑	If yes, briefly describe.

Pregnancy, Delivery & Newborn Periods

Concern	Yes	No	If yes, please explain.
1. Were there any significant complications during the pregnancy?	❑	❑	
2. During the pregnancy, did the mother…			
• Have to take medications?	❑	❑	
• Drink alcohol?	❑	❑	
• Take any drugs?	❑	❑	
3. Were there any significant complications during the delivery?	❑	❑	
4. Was the delivery a Caesarian section?	❑	❑	
5. Was the baby…			
• Premature?	❑	❑	
• In the hospital more than 4 days?	❑	❑	
• Born with any birth defects?	❑	❑	
• Need oxygen at birth?	❑	❑	
• Have seizures?	❑	❑	
• Have an infection?	❑	❑	

Neurodevelopmental Skills

Please rate your child as he/she compares with other children of his/her own age on these skills.

Skill	Better	Average	Worse
1. Catching and throwing a ball	❑	❑	❑
2. Running	❑	❑	❑
3. Building things like models/Legos	❑	❑	❑
4. Drawing/Art	❑	❑	❑
5. Writing	❑	❑	❑
6. Understanding spoken directions	❑	❑	❑
7. Speaking clearly	❑	❑	❑
8. Describing things	❑	❑	❑
9. Ability to remember things	❑	❑	❑

School History

Has your child had any of the following problems in school?

Problem	Yes	No	If yes, through what age/grade did your child have this difficulty?
1. Speech or language problems	❑	❑	
2. Reading problems	❑	❑	
3. Writing problems	❑	❑	
4. Spelling problems	❑	❑	
5. Math problems	❑	❑	
6. Other problems – Please describe.	❑	❑	
7. School placement in a special classroom	❑	❑	
8. Been in a resource classroom	❑	❑	
9. Are you concerned with your child's ability to make or keep friendships with peers?	❑	❑	If yes, briefly describe your concerns.

10. At what age did your child start their first school experience (this can include preschool or kindergarten, whichever was first)?

11. Please list all of the daycare settings and schools your child has attended:

Family History & Structure

Do any family members—including the child's biological parents, grandparents, siblings, aunts, or uncles—have a history of the following conditions?

Condition	Yes	No	If yes, comments?
1. Hyperactivity in childhood	❑	❑	
2. Behavior problems	❑	❑	
3. School difficulties	❑	❑	
4. Learning problems	❑	❑	
5. Being kept back in school	❑	❑	
6. Neurological problems (seizures, tics, Tourette's Syndrome, other)	❑	❑	
7. Intellectual disability	❑	❑	
8. Autism Spectrum Disorder	❑	❑	
9. Other developmental disorder	❑	❑	
10. Alcohol or drug abuse	❑	❑	
11. Sexual or physical abuse	❑	❑	
12. Mental or emotional problem such as anxiety, depression, bipolar disorder, schizophrenia, suicide, etc.	❑	❑	
13. Thyroid disease	❑	❑	
14. PTSD	❑	❑	

Behavioral Approaches at Home

What methods have been used to improve the child's behavior at home?

Method	Yes	No	If yes, comments?
1. Verbal reprimands	❑	❑	
2. Spanking	❑	❑	
3. Withdrawal of privileges	❑	❑	
4. "Grounding" from social activities	❑	❑	
5. Rewards	❑	❑	
6. Time-outs	❑	❑	

7. Which methods have worked best?

Metropolitan Pediatrics, L.L.C.

Children's Sleep Habits (kids 5-12)

Patient Name: ____ Date of Birth: ______/______/ ______

Name of person completing form: __________________ Relationship to patient: ❑ Parent ❑ Guardian ❑ Other: ____________

Directions: The following statements are about your child's sleep habits and possible difficulties with sleep. Think about the **past week** in your child's life when answering the questions. If last week was unusual for a specific reason (such as your child had an ear infection and did not sleep well or the TV was broken), choose the most recent typical week.

Answer "usually" if something occurs **5 or more times** in a week.
Answer "sometimes" if it occurs **2-4 times** in a week.
Answer "rarely" if something occurs **never or 1 time** during a week.

Indicate whether or not the sleep habit is a problem by checking "Yes," "No," or "N/A" (not applicable).

Rating Scale:

1 = Usually (5-7)

2 = Sometimes (2-4)

3 = Rarely (0-1)

Section 1	Rating	Problem?
1. Child goes to bed at the same time at night • *Child's bedtime is _____:_____ pm*		❑ Yes ❑ No ❑ N/A
2. Child falls asleep alone in own bed		❑ Yes ❑ No ❑ N/A
3. Child falls asleep within 20 minutes after going to bed		❑ Yes ❑ No ❑ N/A
4. Child sleeps the right amount • *Child's usual amount of sleep each day (naps) is ______hrs. ______mins.* • *Child's usual amount of sleep each night (no naps) is ______hrs. ______mins.*		❑ Yes ❑ No ❑ N/A
5. Child sleeps about the same amount each day		❑ Yes ❑ No ❑ N/A
6. Child wakes up by him/herself • *Child's usual wake time is _____:_____ am*		❑ Yes ❑ No ❑ N/A

Directions: Please complete Section 2 using the following rating scale:

0 = Not Sleepy 1 = Very Sleepy 2 = Falls Asleep

Section 2: Child has appeared very sleepy or fallen asleep during the following…	Rating
7. Watching TV	
8. Riding in a car	

Directions: Please complete Section 3 using the following rating scale:

1 = Rarely (0-1) 2 = Sometimes (2-4) 3 = Usually (5-7)

Section 3	Rating	Problem?
9. Child falls asleep in parent's or sibling's bed		❑ Yes ❑ No ❑ N/A
10. Child struggles at bedtime (cries, refuses to stay in bed, etc.)		❑ Yes ❑ No ❑ N/A
11. Child needs parent in the room to fall asleep		❑ Yes ❑ No ❑ N/A
12. Child is afraid of sleeping alone		❑ Yes ❑ No ❑ N/A

13. Child sleeps too little		❑ Yes	❑ No	❑ N/A
14. Child is afraid of sleeping in the dark		❑ Yes	❑ No	❑ N/A
15. Child has trouble sleeping away from home (visiting relatives, vacation)		❑ Yes	❑ No	❑ N/A
16. Child moves to someone else's bed during the night (parent, sibling, etc.)		❑ Yes	❑ No	❑ N/A
17. Child awakens once during the night		❑ Yes	❑ No	❑ N/A
18. Child awakens more than once during the night • *A night waking usually lasts ______mins.*		❑ Yes	❑ No	❑ N/A
19. Child talks during sleep		❑ Yes	❑ No	❑ N/A
20. Child is restless and moves a lot during sleep		❑ Yes	❑ No	❑ N/A
21. Child sleepwalks during the night		❑ Yes	❑ No	❑ N/A
22. Child wets the bed at night		❑ Yes	❑ No	❑ N/A
23. Child grinds teeth during sleep (your dentist may have told you this)		❑ Yes	❑ No	❑ N/A
24. Child awakens alarmed by a frightening dream		❑ Yes	❑ No	❑ N/A
25. Child awakens during night screaming, sweating, and inconsolable		❑ Yes	❑ No	❑ N/A
26. Child snores loudly		❑ Yes	❑ No	❑ N/A
27. Child seems to stop breathing during sleep		❑ Yes	❑ No	❑ N/A
28. Child snorts and/or gasps during sleep		❑ Yes	❑ No	❑ N/A
29. Child wakes up in a negative mood		❑ Yes	❑ No	❑ N/A
30. Adults or siblings wake up child		❑ Yes	❑ No	❑ N/A
31. Child has difficulty getting out of bed in the morning		❑ Yes	❑ No	❑ N/A
32. Child takes a long time to become alert in the morning		❑ Yes	❑ No	❑ N/A
33. Child seems tired in the morning		❑ Yes	❑ No	❑ N/A

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Total Score	

Adolescent Sleep Hygiene Scale (teens 13+)

Patient Name: ____ Date of Birth: _____/_____/ _____

Please have the teen patient complete this form.

Directions: Using the choices below, rate how often the following things have happened during the **past month.**

Answer "always" if it happened **100% of the time.**
Answer "frequently, if not always" if it happened **80% of the time.**
Answer "quite often" if it happened **60% of the time.**
Answer "sometimes" if it happened **40% of the time.**
Answer "once in a while" if it happened **20% of the time.**
Answer "never" if it has **not happened.**

Rating Scale:
1 = Always (100%)
2 = Frequently, if not always (80%)
3 = Quite often (60%)
4 = Sometimes (40%)
5 = Once in a while (20%)
6 = Never (0%)

You & Sleep	Rating
1. During the day… I take a nap that lasts more than 1 hour.	
2. … I play or exercise for more than 20 minutes.	
3. After 6:00 in the evening… I have drinks with caffeine (for example: cola, root beer, iced tea, coffee).	
4. … I take a nap.	
5. … I do some kind of physical activity (for example: exercise, play sports).	
6. … I smoke or chew tobacco.	
7. … I drink beer (or some other drinks with alcohol).	
8. During the 1 hour before bedtime… I do things that make me feel calm or relaxed (for example: taking a hot bath/shower, listening to soft music, reading).	
9. … things happen that make me feel strong emotions (sadness, anger, excitement).	
10. … I am very active (for example: playing outside, running, wrestling).	
11. … I do things that make me feel very awake (for example: playing video games, watching TV, talking on the telephone).	
12. … I drink more than 4 glasses of water (or some other liquid).	
13. I go to bed… and do things in my bed that keep me awake (for example: watching TV, reading).	
14. … and think about things I need to do.	
15. … feeling upset.	
16. … and replay the day's events over and over in my mind.	
17. … and worry about things happening at home or at school.	
18. … with a stomachache.	
19. … feeling hungry.	

20. **I fall asleep**… while listening to loud music.	
21. … while watching TV.	
22. … in a brightly lit room (for example: the overhead light is on).	
23. … in one place and then move to another place during the night.	
24. … in a room that feels too hot or too cold.	
25. **I sleep**… in a home where someone smokes cigarettes, cigars, or a pipe.	
26. **I**… get too little sleep.	

For question #27 ONLY, please rate as follows:
1 = Never 2 = Once in a while 3 = Sometimes 4 = Quite often 5 = Frequently, if not always 6 = Always

27. … use a bedtime routine (for example: bathing, brushing teeth, reading).	
28. … use my bed for things other than sleep (for example: talking on the telephone, watching TV, playing video games, doing homework).	
29. … check my clock several times during the night.	
30. **During the school week, I**… stay up more than 1 hour past my usual bedtime. *My usual school night bedtime is ____:____ ❑ am ❑ pm*	
31. … sleep in more than 1 hour past my usual wake time. *My usual school day wake time is ____:____ ❑ am ❑ pm*	
32. **On weekends, I**… stay up more than 1 hour past my usual bedtime. *My usual weekend bedtime is ____:____ ❑ am ❑ pm*	
33. … sleep in more than 1 hour past my usual wake time. *My usual weekend wake time is ____:____ ❑ am ❑ pm*	

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Mean of items 3, 10, 12, 18, 19	
Mean of items 11, 13, 28	
Mean of items 9, 14, 15, 16, 17, 29	
Mean of items 20, 21, 22, 23, 24	
Mean of items 30, 32, 33	
Mean of items 1, 4	
Mean of items 6, 7	
Value of item 27	
Total ASHS Score Mean of all 8 subscales	
Items that are not part of a subscale or the total ASHS score, but were included in the ASHS due to theoretical interest: 2, 5, 8, 25, 26, 31	

Vanderbilt Screen for Attention Deficit Hyperactivity Disorder (ADHD)*

*If you're concerned that your child might have ADHD, please complete this questionnaire for assessment.

Patient Name: ______________________________ Date of Birth: ____/____/ ____

Name of person completing form: ______________ Relationship to patient: ❑ Parent ❑ Guardian ❑ Other: __________

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the **past 6 months.**

Is this evaluation based on a time when the child was…?

- ❑ On medication
- ❑ Not on medication
- ❑ Unsure

Rating Scale:

0 = Never

1 = Occasionally

2 = Often

3 = Very Often

Symptoms	Rating
1. Does not pay attention to details or makes careless mistakes with, for example, homework	
2. Has difficulty keeping attention to what needs to be done	
3. Does not seem to listen when spoken to directly	
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	
5. Has difficulty organizing tasks and activities	
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	
7. Loses things necessary for tasks or activities (e.g., toys, assignments, pencils, books)	
8. Is easily distracted by noises or other stimuli	
9. Is forgetful in daily activities	
10. Fidgets with hands or feet or squirms in seat	
11. Leaves seat when remaining seated is expected	
12. Runs about or climbs too much when remaining seated is expected	
13. Has difficulty playing or beginning quiet play activities	
14. Is "on the go" or often acts as if "driven by a motor"	
15. Talks too much	
16. Blurts out answers before questions have been completed	
17. Has difficulty waiting his/her turn	
18. Interrupts or intrudes in on others' conversations and/or activities	
19. Argues with adults	
20. Loses temper	

21. Actively defies or refuses to go along with adults' requests or rules	
22. Deliberately annoys people	
23. Blames others for his/her mistakes or misbehaviors	
24. Is touchy or easily annoyed by others	
25. Is angry or resentful	
26. Is spiteful and wants to get even	
27. Bullies, threatens, or intimidates others	
28. Starts physical fights	
29. Lies to get out of trouble or to avoid obligations (i.e., "cons" others)	
30. Is truant from school (skips school) without permission	
31. Is physically cruel to people	
32. Has stolen things that have value	
33. Deliberately destroys others' property	
34. Has used a weapon that can cause serious harm (e.g., bat, knife, brick, gun)	
35. Is physically cruel to animals	
36. Has deliberately set fires to cause damage	
37. Has broken into someone else's home, business, or car	
38. Has stayed out at night without permission	
39. Has run away from home overnight	
40. Has forced someone into sexual activity	
41. Is fearful, anxious, or worried	
42. Is afraid to try new things for fear of making mistakes	
43. Feels worthless or inferior	
44. Blames self for problems; feels guilty	
45. Feels lonely, unwanted, or unloved; complains that no one loves him/her	
46. Is sad, unhappy, or depressed	
47. Is self-conscious or easily embarrassed	

Directions: Please complete the Performance section using the following rating scale:

1 = Excellent 2 = Above Average 3 = Average 4 = Somewhat of a problem 5 = Problematic

Performance	Rating
48. Overall school performance	
49. Reading	
50. Writing	
51. Mathematics	

52. Relationship with parents	
53. Relationship with siblings	
54. Relationship with peers	
55. Participation in organization activities (e.g., teams)	

Comments:

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Total number of questions scored 2 or 3 in questions 1–9	
Total number of questions scored 2 or 3 in questions 10–18	
Total Symptom Score for questions 1–18	
Total number of questions scored 2 or 3 in questions 19–26	
Total number of questions scored 2 or 3 in questions 27–40	
Total number of questions scored 2 or 3 in questions 41–47	
Total number of questions scored 4 or 5 in questions 48–55	
Average Performance Score	

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Adapted from the Vanderbilt Rating Scales developed by Mark L.Wolraich, MD.