Metropolitan Pediatrics, L.L.C.

Child & Family Information Form

Patient Name: _____ DOB: _____ MR#: _____ Today's Date: _____

Name of Person Completing Form: _____ Relationship to Patient: _____

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: _____

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Please list all children in the family/household.

Name: _____
Age: _____ School Grade/Occupation: _____

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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?

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 kids of same age)	❑	❑	
• Unwillingness to change daily	❑	❑	
• A time of greatly decreased need for sleep	❑	❑	
• A time when his/her thoughts seemed to be racing	❑	❑	
• 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
• 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 C-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 s/he 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 child have 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)?

11. Please list all 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?