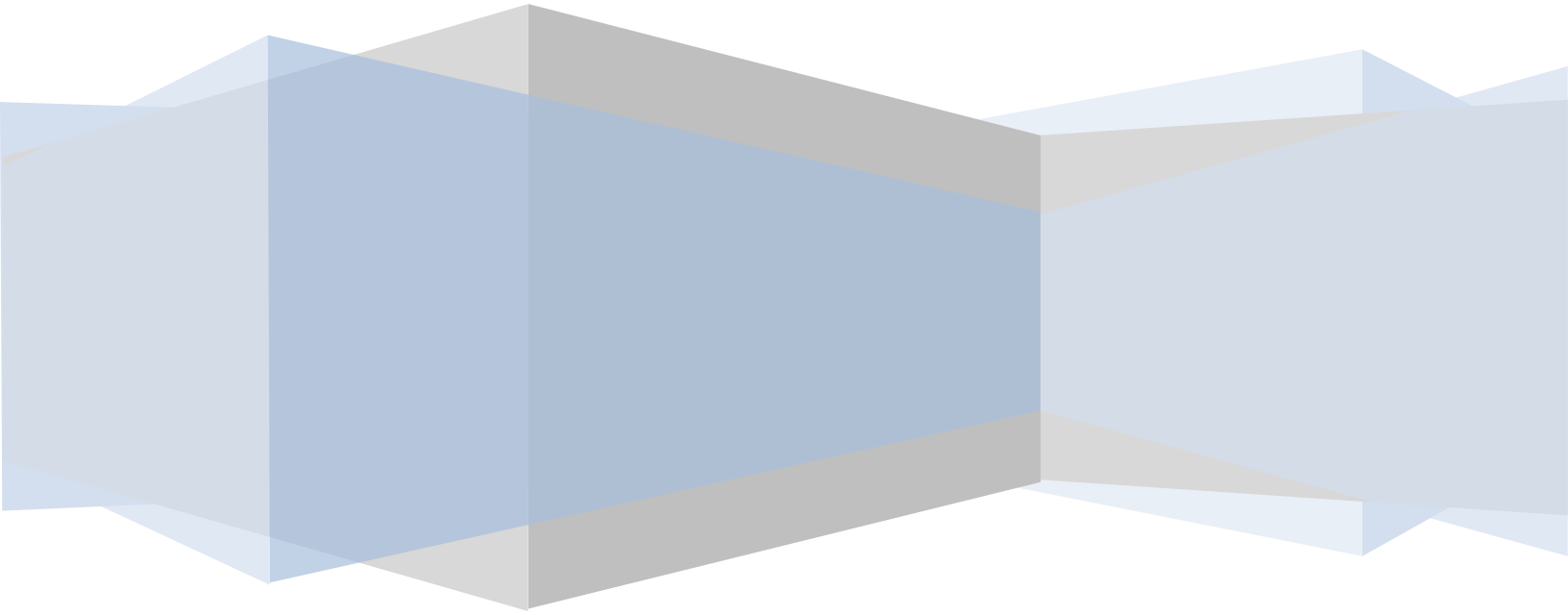
Tullahoma/Manchester/Royal Pediatrics P.L.L.C.

NAME:
_____
DATE GIVEN TO PARENT: _____
DATE RETURNED: _____
APPOINTMENT DATE: _____

CHILDHOOD MEDICAL AND SOCIAL HISTORY

DR. CLIFFORD SEYLER



Child's Name: _____ **Date of Birth**:_____**Age**:____**Sex**: ____
Address: _____

_____

Phone:_____**Phone**: _____

Child resides with: (check all that apply) ☐ biological mother ☐ adoptive mother ☐ biological father ☐ adoptive father ☐ step mother ☐ grandparent(s) ☐ step father ☐ foster parent circle- parent of father or mother
☐ other: _____

Name of current guardian: _____**Phone**: _____

If adopted, Age at the time of placement with adoptive parents: _____Age at the time of adoption: _____

Complete as much of the form as possible, anything you do not know please mark UNKOWN

Mother's Name: _____**Phone**: _____

Father's Name: _____**Phone**: _____

Parents: ☐ never married ☐ married ☐ separated ☐ divorced Age of child at sep/divorce: _____

Please list everyone who resides in the home: _____

_____

How many bedrooms? _____ Do you rent or own? _____

School: _____ Grade: _____
Special Placement (if any): _____

Referred by: _____Phone : _____
Address: _____

Briefly state current problems that influenced desire to seek a behavioral health consultation:

_____

_____

_____

_____

_____

_____

Changes or recent stress: (ex: move to a new home/school, divorce, birth of sibling, domestic violence, bullying at school)____

_____

Pregnancy
Were there any known complications during pregnancy?

Excessive vomiting _____ Excessive blood loss _____ Toxemia ____ High Blood Pressure _____ STD'S _____
X-rays during pregnancy _____ Exposure to TB _____ Flu-like Symptoms/fever _____ Anemia _____ Diabetes ____
Rh Negative _____ Exposure to Lead or Chemicals _____ Hepatitis (A, B or C)_____ Kidney infections _____

	YES	NO	
Smoked during pregnancy	☐	☐	Per day?_____
Caffeine	☐	☐	Amount per day? _____
Consumed alcohol during pregnancy	☐	☐	Per day? _____
Street drugs used	☐	☐	Please specify:_____

(Marijuana, hydrocodone, cocaine, meth)

Prenatal Care began: ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester or ☐ NO PRENATAL CARE
Prenatal Care Provider: _____
Duration of pregnancy: _____weeks Number of years between this pregnancy and previous pregnancy: _____

Delivery

Labor: ☐ Spontaneous ☐ Induced Hours of Duration _____
Multiple Births ☐ Yes ☐ No If yes, how many children: _____
Delivery: ☐ Normal ☐ Breech ☐ Caesarean

Were there any complications such as hemorrhage, cord around neck or infant injured? Yes ☐ No ☐
Explain: _____

_____

Birth Weight: _____ Length: _____ How long was child hospitalized after birth? _____
Did child leave hospital on the same day as parent? _____

Did your child:	YES	NO	EXPLAIN
Require Oxygen immediately after birth?			
Have Jaundice?			
Require transfer to Vanderbilt/Erlanger?			
Have seizures?			
Have a heart murmur?			
Turn blue?			
Require antibiotics?			
Have difficulty with feeding?			

Early Childhood

During the first three years of life, describe how your child…..

Enjoy being cuddled _____
Calmed when held or stroked _____
Comforted easily or not _____
Slept _____
Nursed/fed _____
Banged head (if at all) _____
Explored _____
Was Active _____
Coped with Change _____
Was Outgoing or Withdrawn _____
Displayed Emotions _____
Lived by routines _____
Attended to task _____
Was sensitive to light/sound/texture _____

Did your child receive Speech, Occupational or Physical Therapy or TEIS services prior to the age of 3? ☐ YES ☐ NO

Developmental Milestones (Please indicate if child was normal, early or late in reaching that milestone)

DEVELOPMENTAL MILESTONE	EARLY	NORMAL	LATE	DEVELOPMENTAL MILESTONE	EARLY	NORMAL	LATE
Smiled				Rode tricycle			
Sat without support				Rode bicycle			
Crawled				Buttoned clothing			
Stood without support				Tied shoelaces			
Walked without help				Dressed independently			
Spoke first words				Named colors			
Said phrases				Named letters			
Said sentences				Began to read			
Bladder trained				Began to count			
Bowel trained							

Coordination (Please indicate how coordinated you child is at the following skills)

SKILL	POOR	AVERAGE	EXCELLENT
Catching			
Throwing			
Skipping			
Walking			
Running			
Writing			
Athletic Abilities			

Describe any skills that were rated as poor performance _____

_____

_____

_____

Medical History

Has your child had any childhood illnesses/diseases? Please indicate age:

_____Allergies _____Anemia _____Asthma _____Bladder/Kidney Infection _____ Chicken Pox
_____Colic ____Diabetes _____Digestions Problems _____ Ear Infections _____ Eczema _____ Encephalitis
_____ Fifth's Disease _____Hearing Problems ___ Hepatitis _____Impetigo _____Kawasaki Disease _____ Measles
_____Mumps _____ Pneumonia _____ Rheumatic Fever _____ Rotavirus _____ RSV _____ Scarlet Fever
_____Seizures with fever _____ Seizures without fever _____ Strep Throat _____Vision Problems _____Exposure to environmental toxins (ex. Lead, Mercury) _____Tics/non-purposeful movements _____ Other: _____

Has your child ever been hospitalized? Please indicate age and purpose _____

_____

_____

_____

_____

_____

Has your child ever had an operation? (ex. Circumcision, tubes in ears, cardiac, hernia, appendectomy, adenoids or tonsils removed) Please indicate age and purpose _____

_____

Has your child had accidents resulting in… please describe

Frequent ER visits _____
Broken Bones _____
Eye Injuries _____
Severe Lacerations _____
Burn _____
Stomach pumped _____ _____
Head Injuries /Concussions _____
Stitches _____
Lost teeth _____
Poisoning _____

Are your child's immunizations up-to-date? ☐ YES ☐ NO Please attach records to this history form

Are your child's dental appointments up-to-date? ☐ YES ☐ NO

Has your child had recent changes in appetite? ☐ YES ☐ NO Please describe _____

Sleeping Habits	YES	NO
Does child settle down to sleep well?	☐	☐
Does child sleep through the night?	☐	☐
Does child have nightmares/night terrors?	☐	☐
Does child sleep walk/sleep talk?	☐	☐
Is child a VERY restless sleeper?	☐	☐
Is child insecure (sleep with parents)?	☐	☐
Does child wet bed?	☐	☐

If bedtime and sleeping through the night are problems, give details of a typical night's routine: _____

_____

_____

If mornings are a problem, give details of a typical morning's routine: _____

_____

_____

Bladder and Bowel Habits

Was child easily potty-trained? ☐ YES ☐ NO

Does child wet in pants now? ☐ YES ☐ NO

If yes, please circle when: Day Night Both

how frequently: _____

Does child have bowel accidents now? ☐ YES ☐ NO

If yes, please circle when: Day Night Both

how frequently: _____

Does child have frequent Urinary Infections? ☐ YES ☐ NO

Does your child have frequent constipation? ☐ YES ☐ NO

Past medications for psychological/behavioral problems: Attach a separate sheet if necessary

Date	Prescription	Dose	Response	Physician

Please list any other providers who have treated or currently treating your child: Attach a separate sheet if necessary

Name	Phone Number	Purpose

School Environment

Compared to other children your child's age, how do you see your child's ability to learn? Please circle one

Below Average **Normal** **Above Average**

Friendships Please check the statements that describe your child

☐ Has many friends	☐ Desires friends	☐ Has friends inviting him/her to join them
☐ Has few friends	☐ Most friends are child's age	☐ Most friends are younger/older than child
☐ Prefers to play alone	☐ Does not care about friends	☐ Is shy or withdrawn with others his/her age
☐ Aggressive toward peers	☐ Argues with classmates	☐ Is ignored by classmates
☐ Child is "bossy"	☐ Child compromises well	☐ Behavior causes others to reject child

	YES	NO
Did your child have any behavior problems in daycare/preschool?	☐	☐
Did your child have any behavior problems in kindergarten?	☐	☐
Does your child currently have behavior problems in school?	☐	☐

Has your child repeated any grades? ☐ YES ☐ NO Which grades? _____

Has your child ever been tested for learning problems at school?	☐ YES	☐ NO
Does your child have an IEP (Individual Education Plan)?	☐ YES	☐ NO
Does your child have a tutor or teacher's aide?	☐ YES	☐ NO
Does your child receive Special Education Services or Resource Classes?	☐ YES	☐ NO
Does your child receive Speech, Occupational or Physical Therapy?	☐ YES	☐ NO

Please check yes or no	YES	NO
Child frequently has homework to do at night		
Arguments about homework are common		
Homework is often not completed		
Homework takes more than 2 hours per night		
Is there a regular time to do homework?		
Is there a regular place to do homework?		
Does your child arrive home with all the books and assignments needed?		

Are there problems that the teacher has made you aware of? _____

Are there any additional academic concerns you have? _____

Please provide a sample of your child's handwriting. Please have the child write the sentence below in pencil if possible.

The quick brown fox jumped over the lazy dogs.

FAMILY HISTORY

Biological Mother

Name:_____ Age:____ Date of Birth_____

Occupation: _____ Highest grade completed: _____

Are you disabled? ☐ YES ☐ NO

Learning/Attention/Behavior Problems at school? _____

_____

_____

Medical Problems? ☐ YES ☐ NO if yes, please explain_____

_____

_____

Prescriptions taken regularly: _____

Have you ever had an inpatient hospitalization? ☐ YES ☐ NO If yes, please explain_____

_____

Have you ever been in jail? ☐ YES ☐ NO If yes, please explain_____

_____

Biological Father

Name:_____ Age:____ Date of Birth_____

Occupation: _____ Highest grade completed: _____

Are you disabled? ☐ YES ☐ NO

Learning/Attention/Behavior Problems at school? _____

_____

_____

Medical Problems? ☐ YES ☐ NO if yes, please explain_____

_____

_____

Prescriptions taken regularly: _____

Have you ever had an inpatient hospitalization? ☐ YES ☐ NO If yes, please explain_____

_____

Have you ever been in jail? ☐ YES ☐ NO If yes, please explain_____

_____

Family Psychosocial and Mental Health History (Place a check mark if anyone had/has experienced the following issues)

Psychological/Mental Health	Present Family				Mother's Family				Father' s Family			
	Mom	Dad	Brothers	Sisters	Moms Mom	Moms Dad	Brother (uncles)	Sister (aunts)	Dads Mom	Dads Dad	Brother (uncles)	Sister (aunts)
Aggressive/oppositional or strong-willed behavior as a (c) child or (a) adult												
Hyperactivity, easy to anger, or lack of impulse control as a (c) child or (a) adult												
Attention Problems, difficult focusing on task or activities as a (c) child or (a) adult												
Didn't graduate from high school												
Special Education/learning problems												
Psychosis/Schizophrenia/Bi-Polar/Mood disorders												
Obsessive Compulsive Disorder (OCD)												
Depression for more than 2 weeks												
Anxiety or excessive nervousness												
Austism												
Aspergers												
Tic or Tourette's												
History of Seizures												
Withdrawn or Isolated, Difficulty with socialization												
Mental Retardation												
Alcohol Abuse												
Tobacco Use												
Substance Abuse (marijuana, Hydros, Cocaine, meth)												
Antisocial Behavior (theft, assaults, arrest, etc)												
Arrests/incarcerations												
Suicide/Suicide Attempts												
Trauma												
Physical Abuse (V) victim or (O)Offender												
Sexual Abuse (V) Victim or (O) Offender												

Social History

Does your child have more temper tantrums than average children his/her age? If so, describe what an outside observer might see and for how long these tantrums might last _____

_____

Is the relationship with parents typical of a child his/her age? ☐ Yes ☐ No If no, please explain _____

_____

Do parents/guardians in the home agree on discipline in the home? ☐ YES ☐ NO If no, please explain _____

Please list forms of discipline used that work

Please list forms of discipline that you found do not work

Have you ever attended parenting classes or counseling? ☐ YES ☐ NO if yes, explain _____

Is the relationship with siblings typical of a child his/her age? ☐ YES ☐ NO If no, explain _____

Are you concerned about how your child treats the family pet (s)? ☐ YES ☐ NO If yes, explain _____

Has your child ever experienced a trauma, such as a fire, physical or sexual abuse? ☐ YES ☐ NO If yes, explain _____

All children exhibit some behaviors that are more intense than other children their age, please mark yes if you feel your child exhibits a behavior that is more extreme than children the same age.

Behavior	Yes	Behavior	YES
Careless mistakes		Blurts out answers	
Difficulty paying attention		Difficulty remaining seated	
Does not listen		Runs/climbs when should be seated	
Difficulty finishing task		Difficulty playing quietly	
Poor organizational skills		Always on the go	
Avoids task of long duration		Talks excessively	
Loses necessary items		Difficulty waiting his/her turn	
Easily distracted		Interrupts others	
Forgetful		Fidgets with hands/feet/squirms	
Argues with adults		Fearful, anxious or worried	
Loses temper		Afraid to try new things	
Actively defiant with adults		Feels worthless or inferior	
Deliberately annoys other people		Blames self for problems	
Blames others for mistakes		Lonely, unwanted	
Easily annoyed by others		Sad, unhappy or depressed	
Is angry or resentful		Self-conscious, easily embarrassed	
Spiteful			
Physically cruel towards others		Has considered/attempted suicide	
Bullies		Has hurt him/herself	
Starts physical fights		Withdrawn/Isolated	
Lies to get out of trouble		Refuses to be alone	
Truant		Has consumed alcohol	
Steals things		Has used illegal drugs	
Deliberately destroys others' property		Uses tobacco	
Used a weapon to harm others		Has shown increased interest in sex	
Physically cruel to animals		Touches self excessively for his/her age	
Has set fires to cause damage		Has become sexually active	
Has run away overnight		Unusually affectionate with strangers	
Broken into someone else's home or car		Unusual crying spells	
Stays out all night		Exhibits poor judgment	
Forces sexual activity		Doesn't appear to learn from experience	