LINDEN
BEHAVIORAL PEDIATRICS
Exceptional Care for Youth & Families

PEDIATRIC HISTORY FORM

Please complete the following form about your child online or print and mail prior to the first appointment. Thank you!

Today's Date _____ Referred by _____

Person Completing Form _____ Relationship to Patient _____

Child's Name _____ Child's Birthday _____ Age _____

Home Address _____ City, State _____ Zip _____

Child Lives with: ( ) Both Parents ( ) Father ( ) Mother ( ) Foster Parents ( ) Other _____

Mother's Name _____ Birthdate _____

Occupation _____ Employer _____

Preferred Phone _____ Work Phone _____

Father's Name _____ Birthdate _____

Occupation _____ Employer _____

Preferred Phone _____ Work Phone _____

Siblings (Names and Ages) _____

_____

Others in Home (if applicable) _____

If parents are divorced, please provide information about custody, visitation schedule, and addresses

_____

_____

What are the primary concerns regarding your child?

_____

_____

_____

_____

_____

Concerns about child (circle all that are appropriate)**:**

anxiety/worry	behavior problems	trouble calming down
sad/depressed	attention problems	overly energectic
problems with sibling(s)	disobedient	lacks self-control
limited friendships	withholds affection	uncomfortable with new
reading difficulty	hides feelings	ppl
math difficulty	seems impulsive	
poor school work	overreacts to problems	

Problem(s) has/have been going on: weeks months year or more

Child: (circle a number) Disrupts _____ Gets along well with family

1 2 3 4 5 6 7 8 9 10

Parents generally: agree disagree on how to discipline child

Discipline has been: strict lenient inconsistent

Comment:

_____

_____

_____

PREGNANCY AND BIRTH

Pregnancy normal complications

_____

Substance use during pregnancy ( ) Alcohol ( ) Marijuana ( ) Cigarettes ( ) Prescription Meds

Length of Pregnancy _____ weeks

Birth vaginal c-section

Complications during labor or delivery

_____

Length of stay in hospital: Mother _____ days Child _____days

DEVELOPMENT

Please indicate the age the following motor and language skills were acquired. If you do not recall, indicate if it was early, within expected limits (normal), or delayed. If it isn't yet acquired, put n/a.

Roll over	_____	Ride 2-wheeler	_____
Sit alone	_____	Tie shoes	_____
Stand alone	_____	Speak 1st words	_____
Walk alone	_____	Speak sentences	_____
Pedal tricycle	_____	Toilet trained	_____

_____

Education

Please complete where appropriate for your child.

Early Intervention (0-3 years)( ) Yes ( ) No

If yes, please indicate which therapies and how often (hours/week):

Speech/Language _____ Occupational therapy _____

Physical therapy _____ Social Group _____

Interventionist _____ Other _____

Preschool _____ How many years? _____

Teacher/staffcomments/concerns_____

_____

Current School _____ Grade _____

Teacher Concerns Past ( ) Yes ( ) No If yes, what?_____

Present ( ) Yes ( ) No If yes, what? _____

Describe current academic performance_____

What concerns do you have related to your child and school _____

_____

Has your child ever had an MFE ( ) Yes ( ) No If yes, at what age_____

Does your child have a 504 Plan ( ) Yes ( ) No IEP ( ) Yes ( ) No

Has your child…

been retained a grade in school ( ) Yes ( ) No If yes, when and why? _____

skipped a grade in school ( ) Yes ( ) No If yes, in what grade? _____

Please indicate which are true for your child…

difficulty with reading _____

difficulty with writing _____

difficulty with math _____

poor grades _____

dislike of school _____

frequent absences _____

Friendships

Please complete where appropriate for your child

problems relating to peers _____ difficulty making friends _____

fights frequently with playmates_____ prefers to play alone _____

prefers to play with older peers_____

prefers to play with younger peers _____

Recreation/Interests

What activities does this child enjoy? _____

_____

Favorite way to spend free time _____

Medical

Pediatrician/PCP _____ Address _____

Describe any significant medical problems _____

_____

List any medications_____

Does child wear glasses or contacts? ( ) Yes ( ) No Child's eye doctor is _____

Has child had a hearing evaluation? ( ) Yes ( ) No When and where? _____