

# ADVANCED PEDIATRIC ASSOCIATES

## Behavioral Assessment Questionnaire

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name of person completing this form: \_\_\_\_\_ Relationship: \_\_\_\_\_

In your own words, what is the reason for this visit? \_\_\_\_\_

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What help are you seeking from Advanced Pediatrics? \_\_\_\_\_

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Is this evaluation for (check all that apply)?:  First-Time Evaluation  Second Opinion

Updated Evaluation  Consider Medication for \_\_\_\_\_

Please list any social workers, therapists, school staff, or other professionals currently involved in the child's welfare, or any educational plans in place: \_\_\_\_\_

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List any previous developmental, school, or mental health evaluations for the child—when, where, results: \_\_\_\_\_

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Is or has your child ever taken any medication for an emotional, behavioral, or mental health problem? If so, what and when? Include herbal or over-the-counter medication. \_\_\_\_\_

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### Family Medical History

Indicate any relatives of the child with any of the following problems.

	Brothers Sisters	Natural Mother	Mother's Relatives	Natural Father	Father's Relatives
Obsessive-Compulsive disorder or fussy habits, picky, rigid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tics or other nervous habits, Tourette's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression for more than 2 weeks, medications for mood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide or attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychosis or schizophrenia, hospitalized for mental or emotional problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal problems, arrests, jail/prison time, court probations, "always in trouble"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serious or chronic medical problems: cancer, deafness, heart problems, seizures, diabetes, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gambling, shopping or other compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is there anything else we should know about your child or family? \_\_\_\_\_

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