

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

NAME: _____

DATE GIVEN TO PARENT: _____

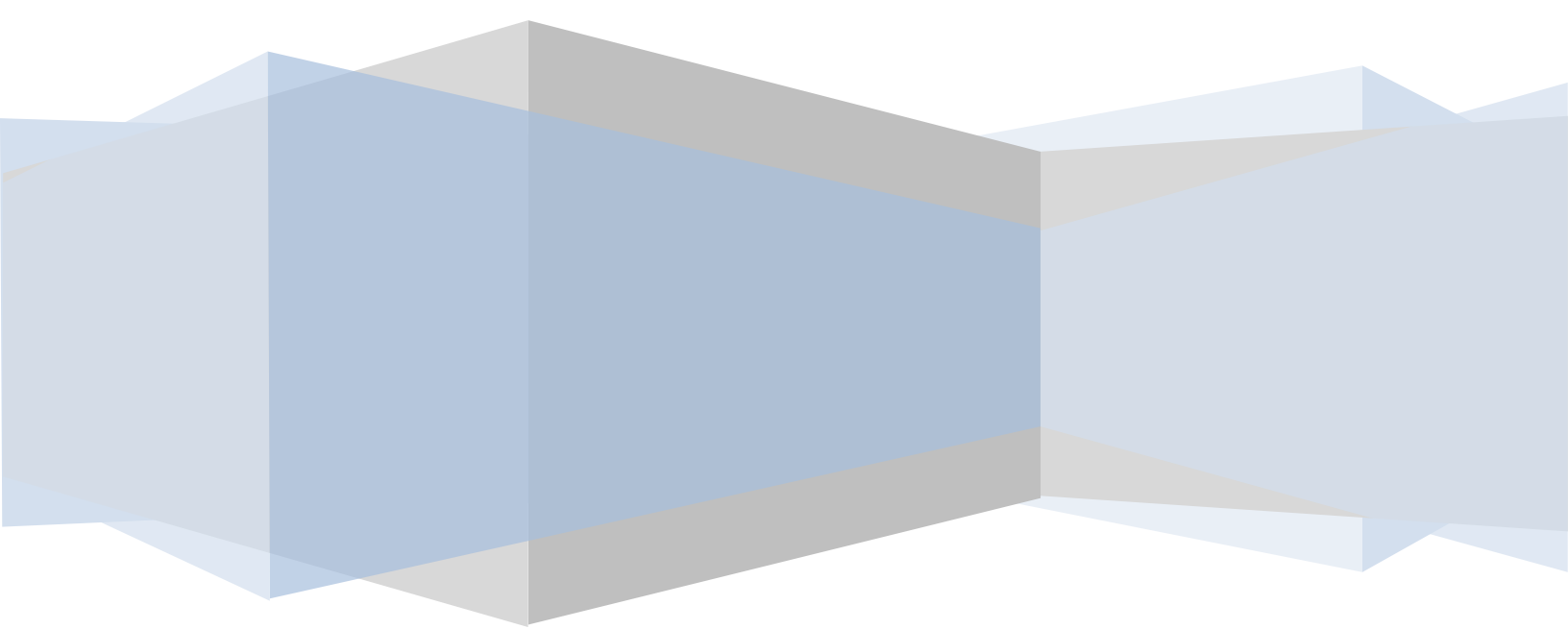
DATE RETURNED: _____

APPOINTMENT DATE: _____

Contact #: _____

CHILDHOOD MEDICAL AND SOCIAL HISTORY

DR. CLIFFORD SEYLER



Child's Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Address: _____

Phone: _____ Phone: _____

Child resides with: biological mother biological father step mother step father foster parent
(check all that apply) adoptive mother adoptive father grandparent(s) 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	<input type="checkbox"/>	<input type="checkbox"/>	Per day? _____
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	Amount per day? _____
Consumed alcohol during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Per day? _____
Street drugs used (Marijuana, hydrocodone, cocaine, meth)	<input type="checkbox"/>	<input type="checkbox"/>	Please specify: _____

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? YES NO
- Does child sleep through the night? YES NO
- Does child have nightmares/night terrors? YES NO
- Does child sleep walk/sleep talk? YES NO
- Is child a VERY restless sleeper? YES NO
- Is child insecure (sleep with parents)? YES NO
- Does child wet bed? YES NO

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

Does child have bowel accidents now? YES NO

If yes, please circle when: Day Night Both

If yes, please circle when: Day Night Both

how frequently: _____

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

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	