**American Health Network of Ohio**
Pediatrics in Grove City
4074 Gantz Road
Grove City, Ohio 43123
614.871.8500 fax 614.871.4803
www.ahni.com/gcpeds

# BEHAVIORAL QUESTIONNAIRE

The information on this questionnaire will help us to better evaluate your child when you come to our office. If your child attends school, please bring your child's most recent grade card for us to review. Please fill this out as soon as possible and return it to the above address. Thank you.

**Name:** ________________________________________ **DOB:** ___________ **Age:** __________

**Parents:**
**Mother's Name:** ________________________________________________________________

**Father's Name:** _________________________________________________________________

**Address:** ______________________________________________________________________

**Phone**
**Home:** _______________ **Mother's Cell:** _______________ **Father's Cell:** ______________

**Mother's Occupation:** ____________________________________________________________
**Work Phone:** ____________________________

**Father's Occupation:** ____________________________________________________________
**Work Phone:** _____________________________

**Education: please indicate grade level completed**

**Mother:** _________________________________

**Father:** _________________________________

# History

1. What prompted your request for a behavioral evaluation?

2. When did you or others first notice a problem? Please explain.

3. Are the problems worse at home or at school? Please explain.

4. Does your child have a problem with attention? If yes, give 3 examples.

5. Is your child extremely hyperactive, fidgety, restless, etc? if yes, give 3 examples.

6. Does your child act impulsively (without thinking, gets into dangerous situations, can't wait turn)? If yes, give examples.

7. Please list your child's greatest strengths (good points and abilities).

8. What does your child enjoy doing with leisure "free" time?

## Educational History

1. Did your child attend a preschool program?

   A. Were there any concerns about your child's ability to learn?

   B. Were there any concerns about your child's ability to get along with others?

2. Has your child ever had any psychological or educational testing done? If yes, when was it done?

3. Has your child ever repeated a grade or been "held back"? If yes, which grade?

4. Has your child been expelled or suspended from school during the past year? If yes, how many times?

5. Has your child been placed in PEAK or disciplinary classes during the most recent school year? If yes, how many times and why?

6. Did you have any concerns about your child's early development before starting school?

   A. In which area were you concerned? Please circle all that apply.
      Motor development
      Social development
      Speech or language development
      Emotional development

# Medical history

1. Pregnancy & delivery
    A. Length of pregnancy? __________
    B. Mother's age when child was born? __________
    C. Child's birth weight? __________
2.

| Did Mom or the infant experience any of the following during pregnancy or delivery? | Yes | No |
|---|---|---|
| Bleeding | | |
| High blood pressure | | |
| Serious illness or injury | | |
| Took prescription medications | | |
| Alcohol or drug use | | |
| Smoked cigarettes | | |
| Had an infection | | |
| Delivery by cesarean | | |
| Breech birth | | |
| Baby turned yellow (jaundice) | | |
| Baby turned blue (cyanosis) | | |
| Other | | |

3.Has the child ever been hospitalized? Please list the times, reasons and the name of the hospital.

# Health History

| Has your child ever had | Never | In past | Presently |
|---|---|---|---|
| Asthma | | | |
| Allergies | | | |
| Seizures | | | |
| Heart or blood pressure problems | | | |
| Broken bones | | | |
| Head injury with loss of consciousness | | | |
| Lead poisoning | | | |
| Speech or language problems | | | |
| Chronic ear infections | | | |
| Eye/ vision problems | | | |
| Fine motor problems (handwriting) | | | |
| Gross motor problems (clumsiness) | | | |
| Soiling problems (having BM in pants) | | | |
| Bedwetting problems | | | |

4. Any other health conditions you like us to know about?

5. Is your child taking any medications now?

## Family History

1. Who is living in the home at this time? (name/age/relation)

2. Family members living outside of the home?

3. If parents are divorced or separated, how often does you child visit the parent he/she does not live with?

4. The following is a checklist of problems. Please mark the column if any family members have/ had the problem.

| | Birth mother | Birth father | Birth siblings | Birth Grandparents | others |
|---|---|---|---|---|---|
| Speech or language problems | | | | | |
| "Held back" in school | | | | | |
| Mental retardation | | | | | |
| ADD/ADHD | | | | | |
| Behavioral problems in school | | | | | |
| Trouble learning to read | | | | | |
| Suicide or attempted | | | | | |
| Depression | | | | | |
| Anxiety | | | | | |
| Drug or alcohol | | | | | |
| Diagnosed manic depression | | | | | |
| Victim of physical abuse | | | | | |
| Victim of sexual abuse | | | | | |
| Seizures | | | | | |

5. Have there been any of the following changes in the last year among family members?

| | No | Yes | Family Member |
|---|---|---|---|
| Marriage | | | |
| Separation or divorce | | | |
| Marital problems | | | |
| Pregnancy | | | |
| Birth | | | |
| Death | | | |
| Health problems | | | |
| Psychiatric problems | | | |
| Loss of job | | | |
| Financial problems | | | |
| Legal problems | | | |
| Alcohol / Drug problems | | | |
| Other | | | |

6. Is your child having any of the following problems at home?

| | No | Yes | Explain |
|---|---|---|---|
| Does not obey parents | | | |
| Does not get along with sibling /friends | | | |
| Overactive / Restless | | | |
| Tries to break or destroy things | | | |
| Does not act appropriate for age | | | |
| Does not relate well to others | | | |
| Tries to hurt others | | | |
| Other | | | |

7. Is your child experiencing any of the following problems?

| Problem | No | Yes | Explain |
|---|---|---|---|
| Seems depressed | | | |
| Has low self-esteem | | | |
| Easily bored | | | |
| Sleep problems | | | |
| Anxious or nervous | | | |

8.Is your child having any of the following problems at school?

| Problem | No | Yes | Explain |
|---|---|---|---|
| Trouble with friends | | | |
| Discipline problems | | | |
| Learning problems | | | |
| Other | | | |

16. Are any of the following types of discipline used at home?

| | No | Yes | How well does it work? |
|---|---|---|---|
| Time out | | | |
| Taking away TV or other privileges | | | |
| Spanking | | | |
| Yelling | | | |
| Extra chores | | | |
| Grounding | | | |
| Ignoring the behavior | | | |
| Talking it over | | | |
| Regular praise for appropriate behavior | | | |
| Reinforcements / rewards for behavior (e.g. money, privileges) | | | |
| Other | | | |

18. Please add any information you feel will help us better understand your child:

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Person completing form: _______________________________________Date: ____________
Relationship to child: ____________________________________________________________

Thank you for taking the time to complete this form. We look forward to meeting with you and your child.