Banner Health

# NEW PATIENT MEDICAL HISTORY
# BEHAVIORAL HEALTH PEDIATRIC

Patient Name: _____ Date of Birth: _____

Gender Identity (Optional) _____

## Current Mental Health Providers

**Counselor/Therapist** Name _____ Phone _____

**Psychiatrist** Name _____ Phone _____

Specialty _____

**Current School** _____ School Phone _____

Contact Name _____

Current grade level _____ Average grades _____

Homework problems _____

_____

## Current Concerns

Please describe your child's problem(s) (that is, the concerns that brought you here today):

When did these problems begin?

Please give examples of the problem:

Why do you think your child is having this particular problem?

## Challenging Behavior

1. Record each problem behavior the individual displays and describe it specifically. Include any damage resulting from the problem behavior either to the individual or others. Please rank in order of concern to yourself or other caretakers.

| | Behavior | Description |
|---|---|---|
| A. | _____ | _____ |
| B. | _____ | _____ |
| C. | _____ | _____ |
| D. | _____ | _____ |
| E. | _____ | _____ |
| F. | _____ | _____ |
| G. | _____ | _____ |

Banner Health

## NEW PATIENT MEDICAL HISTORY
## BEHAVIORAL HEALTH PEDIATRIC

Patient Name: _____ Date of Birth: _____

2. Estimate the severity of the problem behavior of greatest concern (circle one)
   Moderate Severe Life-threatening
3. Has the individual ever been sent to the hospital to treat an injury resulting from the behavior? No Yes
   Describe: _____
4. Has the individual ever sent someone else to the hospital to treat an injury resulting from the behavior? No Yes
   Describe: _____
5. Has the individual ever been hospitalized to develop a treatment for these behavior problems? No Yes
   Describe: _____
6. In what settings do these behaviors occur?
   a. Home
   b. School
   c. Community: specify _____
   d. Other: _____
7. Estimate the current frequency of the problem behavior(s) (circle one).
   a. Less than one episode per week (list frequency)
   b. 1 to 3 episodes per seek
   c. Occurs about once daily
   d. Occurs several times per day
   e. Occurs every hour while awake
8. How long has the individual been engaging in the problem behavior(s) (circle one)?
   a. Within past 6 months
   b. More than 6 months but less than 1 year
   c. More than 1 year but less than 3 years
   d. More than 3 years but less than 5 years
   e. More than 5 years but less than 10 years
   f. More than 10 years
9. When is the problem behavior(s) likely to occur (circle all that apply)
   a. When individual is left alone or unattended
   b. When lots of people are around
   c. When demands are placed on the individual
   d. Mealtimes, dressing or bathing (circle)
   e. Time of day: _____
   f. Other: _____
10. Are there any occasions when the problem behavior(s) rarely or never occurs?
    _____
    _____
11. a. How do people (staff, parents, etc.) typically respond when the individual engages in the problem behavior(s)?
    _____
    (If a formal program is currently being conducted, refer to it here and send a copy)
11. b. How long has the program been in place? _____
    _____
12. Estimate the general trend of the problem behavior(s) during the past year (circle one)
    a. Increasing (behavior getting worse) b. Decreasing (behavior getting better) c. Stable (about the same)
13. Does the individual display aggressive behavior toward staff or peers? If yes, explain: _____
    _____
    _____
    _____



5100-0055
(01/2019)

Banner Health

## NEW PATIENT MEDICAL HISTORY
## BEHAVIORAL HEALTH PEDIATRIC

Patient Name: _____ Date of Birth: _____

14. Was the onset of the problem behavior(s) associated with any specific event or series of events?

_____

_____

_____

Have the following procedures ever been used to treat the problem behavior(s)? (circle all that have been used)

a. Restraint

Describe: _____

_____

Start Date: _____ Still used? No / Yes Stop Date: _____

Estimated degree of success:

_____

_____

_____

Which problem behavior(s) was the treatment indicated for?

_____

_____

b. Protective Equipment

Describe: _____

_____

Start Date: _____ Still used? No / Yes Stop Date: _____

Estimated degree of success:

_____

_____

Which problem behavior(s) was the treatment indicated for?

_____

_____

_____

c. Behavior Modification - positive reinforcement

Describe: _____

_____

Start Date: _____ Still used? No / Yes Stop Date: _____

Estimated degree of success:

_____

_____

Which problem behavior(s) was the treatment indicated for?

_____

_____



5100-0055
(01/2019)

Banner Health

## NEW PATIENT MEDICAL HISTORY
## BEHAVIORAL HEALTH PEDIATRIC

Patient Name: _____ Date of Birth: _____

d. Behavior Modification - punishment
Describe: _____

_____

Start Date: _____ Still used? No / Yes Stop Date: _____
Estimated degree of success:

_____

_____

Which problem behavior(s) was the treatment indicated for?

_____

_____

e. Other Describe: _____

_____

Start Date: _____ Still used? No / Yes Stop Date: _____
Estimated degree of success:

_____

_____

Which problem behavior(s) was the treatment indicated for?

_____

What are your goals for consulting with our clinic? That is, what would you like to happen?

1. _____
2. _____
3. _____
4. _____

What feelings does your child MOST OFTEN show when faced with stress or other problems? (i.e. anger, fear, sadness, etc.)

What seems to help your child deal with stress or problems?

What seems to make things worse?



5100-0055
(01/2019)

Banner Health

## NEW PATIENT MEDICAL HISTORY
## BEHAVIORAL HEALTH PEDIATRIC

Patient Name: _____ Date of Birth: _____

### Life Stress

**Major Stresses:** Please mark if any of the following events have happened to your child in the past TWO YEARS?
*Check all that apply:*

- ❑ Moving to a new home
- ❑ Change to a new school
- ❑ Parents fighting
- ❑ Parents separated
- ❑ Parents divorced
- ❑ New stepmother or stepfather
- ❑ Mother or father lost a job
- ❑ Mother or father got a new job
- ❑ Change in parent's financial status
- ❑ Increased absence of a parent
- ❑ Parent in trouble with the law
- ❑ Parent went to jail
- ❑ Child had major personal injury/illness
- ❑ Serious illness or injury in the family
- ❑ Death of a family member
- ❑ Serious illness of a friend
- ❑ Boyfriend/girlfriend/friend having operation
- ❑ Male: Girlfriend become pregnant
- ❑ Female: Became pregnant
- ❑ Death of a friend
- ❑ Loss of a pet
- ❑ Got a new pet
- ❑ Got own car
- ❑ New brother or sister
- ❑ Trouble with a brother or sister
- ❑ More arguments with parents
- ❑ Less arguments with parents
- ❑ Getting a new boyfriend/girlfriend
- ❑ Breaking up with boyfriend/girlfriend
- ❑ Making up with boyfriend/girlfriend
- ❑ Losing a close friend
- ❑ Got a new job
- ❑ Lost a job
- ❑ Special recognition for good grades
- ❑ Making the honor role
- ❑ Joining a new club
- ❑ Making an athletic team, cheerleading, etc.
- ❑ Failing to make athletic team, cheerleading, etc.
- ❑ Trouble with teacher
- ❑ Trouble with classmates
- ❑ Making failing grades in school classes
- ❑ Failed a grade/put back a grade
- ❑ Skipped a grade/put ahead a grade
- ❑ Got suspended from school
- ❑ Got into trouble with the police
- ❑ Got put into detention, jail

### Sleep

Where does your child sleep? *Please check all that apply.*

- ❑ Own bed
- ❑ Shares a bed. If so, with whom? _____
- ❑ Other (couch, floor, etc.) _____
- ❑ Own room
- ❑ Shares a room. If so, with whom? _____

What time does child usually go to bed on SCHOOL days? _____

What time does child usually go to bed on WEEKENDS? _____

| How long (in minutes) does it usually take for child to fall asleep each night? | 15 or less | 16 – 30 | 31 – 60 | 61 or more |
|---|---|---|---|---|
| | ❑ | ❑ | ❑ | ❑ |

Problems falling asleep? ❑ No ❑ Yes If yes, please describe: _____

Problems staying asleep? ❑ No ❑ Yes If yes, please describe: _____



5100-0055
(01/2019)

Banner Health

## NEW PATIENT MEDICAL HISTORY
## BEHAVIORAL HEALTH PEDIATRIC

Patient Name: _____ Date of Birth: _____

On average, how many hours does your child sleep at night?

❑ Less than 6 hours ❑ 7 – 8 hours ❑ 9 hours ❑ 10 hours ❑ More than 10 hours

What time does child usually wake up on SCHOOL days? _____

What time does child usually wake up on WEEKENDS? _____

Problems waking up? ❑ No ❑ Yes If yes, please describe: _____

How often does your child take a nap?

❑ Never ❑ 1 – 2 days per week ❑ 3 – 6 days per week ❑ Every day

There is a television in my children's room. ❑ No ❑ Yes

Any current or history of: *Check all that apply*

| | | |
|---|---|---|
| ❑ Loud Snoring | ❑ Sleep Terrors | ❑ Awaken gasping for breath or choking |
| ❑ Restless Sleep | ❑ Dry mouth | ❑ Irresistible urge to move legs or arms |
| ❑ Sleepy during the day | ❑ Grinds teeth | ❑ Bedwetting at night |
| ❑ Mouth breathing | ❑ Sleep Walking | ❑ Recurrent nightmares |
| ❑ Observed apnea (stops breathing) while sleeping | | ❑ Pain in legs at night |

### Diet and Nutrition

Is your child currently on a special diet? (e.g., vegetarian, vegan, high protein, gluten free) ❑ No ❑ Yes

If yes, please list dietary restrictions: _____

How many meals per week does your family eat together where your child is present?

❑ None ❑ 1 – 5 ❑ 6 – 10 ❑ 11 – 15 ❑ 16 or more

How many mornings per week does your child eat breakfast?

❑ None ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7

The amount of certain foods and beverages your child eats on an AVERAGE day:

| | | | | |
|---|---|---|---|---|
| Soda (glasses, cups, or cans of Coke, Pepsi, etc) | ❑ None | ❑ 1 | ❑ 2 or more | ❑ Don't know |
| Caffeinated tea (cups of iced tea or hot tea) | ❑ None | ❑ 1 | ❑ 2 or more | ❑ Don't know |
| Caffeinated coffee (8 ounce cups) | ❑ None | ❑ 1 | ❑ 2 or more | ❑ Don't know |
| Energy drinks (cans, glasses, or cups) | ❑ None | ❑ 1 | ❑ 2 or more | ❑ Don't know |
| Fast Food | ❑ None | ❑ 1 | ❑ 2 or more | ❑ Don't know |
| Restaurant meals (including take out) | ❑ None | ❑ 1 | ❑ 2 or more | ❑ Don't know |
| Prepackaged meals (including frozen meals) | ❑ None | ❑ 1 | ❑ 2 or more | ❑ Don't know |
| Servings of fruit | ❑ None | ❑ 1 | ❑ 2 or more | ❑ Don't know |
| Servings of vegetables | ❑ None | ❑ 1 | ❑ 2 or more | ❑ Don't know |

### Physical Activity and Exercise

How many days a WEEK does your child spend at least 60 minutes in physical exercise that made child breathe hard and increase heart rate (running, swimming, riding a bicycle, playing sports):

❑ None ❑ 1-2 days ❑ 3-4 day ❑ 5-6 days ❑ 7 days



5100-0055
(01/2019)

Banner Health

## NEW PATIENT MEDICAL HISTORY
## BEHAVIORAL HEALTH PEDIATRIC

Patient Name: _____ Date of Birth: _____

Does your child have and attend Physical education (PE) class at school:
❑ No ❑ Yes ❑ Don't know

### Screen Time

For an average day, how many hours does your child spend:
Watching TV _____
Playing video games _____
Using computer _____
Cell phone _____
Other electronic device _____
Playing video games: include online games, X Box, Play Station, iPad/tablet, iPhone/smartphone
Using a computer: school work, internet, emailing, Skype. DO NOT include video games
Cell phone, other electronic device: for texting, talking with friends, etc.

### Child's Past Psychiatric or Mental Health Care

Past Psychiatric Medications
What prescription psychiatric medications have been tried with your child in the PAST? Include all medications that have been prescribed by a doctor or other health care provider (if you have them, please bring all medication bottles to your first visit).

| Name of Past Psychiatric Medication | Strength (Ex: 50 mg, 5 units) | Dose (Ex: 1 capsule daily, 1 teaspoon twice a day) | Reason Started | Side Effects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Has your child EVER seen a therapist or counselor before? (e.g., psychologist, social worker, school counselor)
❑ No ❑ Yes If yes, when and why? _____

Has your child EVER seen a psychiatrist before? ❑ No ❑ Yes If yes, when and why? _____

Does the child have a history of:
❑ Seizures ❑ Concussions ❑ Head traumas
❑ Passing out ❑ Palpitations (rapid heartbeat) ❑ Heart murmur
❑ Rheumatic fever ❑ Chest pain or shortness of breath with exercise
❑ High blood pressure ❑ Reflux
Does the child have a history of eczema ❑ No ❑ Yes If yes, when diagnosed: _____


5100-0055
(01/2019)

Banner Health

## NEW PATIENT MEDICAL HISTORY
## BEHAVIORAL HEALTH PEDIATRIC

Patient Name: _____ Date of Birth: _____

**FOR GIRLS:**

Has your daughter begun menstruation (having her periods)? ❑ No ❑ Yes If yes, at what age? _____

Are her menstrual cycles ❑ Regular (every 28 days) ❑ Not regular (3 weeks, 5 weeks)

Does she have significant mood changes that go along with her monthly cycles? ❑ No ❑ Yes

If yes, please describe: _____

Does your daughter take birth control? ❑ No ❑ Yes

### Review of Systems:

Please indicate by your child has had any of the following medical problems within the past month. *Check all that apply.*

**General**
- ❑ Fever
- ❑ Fatigue
- ❑ Recent weight loss or gain
- ❑ Restriction of numerous foods
- ❑ Heat or cold intolerance
- ❑ Difficulty sleeping

**Head, Eyes, Ears, Nose, Mouth, Throat**
- ❑ Headache
- ❑ Dizziness
- ❑ Loss of hair
- ❑ Swollen glands
- ❑ Red or irritated eyes
- ❑ Ringing in ears
- ❑ Dry mouth
- ❑ Bad breath
- ❑ Mouth sores
- ❑ Sore throat
- ❑ Voice changes
- ❑ Swollen glands
- ❑ Running nose
- ❑ Post nasal drip

**Respiratory**
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Chest pain on taking a deep breath
- ❑ Other chest pain or tightness
- ❑ Cough

**Genitourinary**
- ❑ Pain with urination
- ❑ Increase in frequency or urgency in urinating
- ❑ Blood in urine

**Cardiovascular**
- ❑ Irregular heart beat
- ❑ Murmur
- ❑ Palpitations

**Bones, Muscles, Joints**
- ❑ Morning stiffness
- ❑ Joint pain
- ❑ Joint swelling
- ❑ Muscle pain
- ❑ Neck pain
- ❑ Low back pain
- ❑ Numbness or tingling

**Skin**
- ❑ Rash over cheeks
- ❑ Hives or welts
- ❑ Easy bruising
- ❑ Sun sensitivity
- ❑ White, blue, or red skin color change in fingers when exposed to cold
- ❑ Strong foot odor

**Gastrointestinal**
- ❑ Loss of appetite
- ❑ Difficulty swallowing
- ❑ Heartburn, indigestion
- ❑ Nausea
- ❑ Vomiting
- ❑ Pain or cramps in abdomen
- ❑ Abnormal stool patterns
- ❑ Bloated abdomen and gas/burping
- ❑ Diarrhea
- ❑ Constipation
- ❑ Blood in stools
- ❑ Vomiting blood

### Family History

Questions in this section are separated between biological parents and guardians/foster parents. If you are a guardian or foster parent, please first answer what you know about the child's biological mother and father. Then, move to the section about yourself.

### Biological Parents

**Biological Mother**

Biological mother's current age: _____

If deceased, age at death and cause of death: _____

Biological mother's race/ethnicity:

❑ American Indian ❑ Alaska Native ❑ Asian ❑ Black / African American ❑ Hispanic / Latino ❑ Middle Eastern Indian
❑ Native Hawaiian / Other Pacific Islander ❑ Other _____ ❑ Unknown



5100-0055
(01/2019)

Banner Health

## NEW PATIENT MEDICAL HISTORY
## BEHAVIORAL HEALTH PEDIATRIC

Patient Name: _____ Date of Birth: _____

Biological mother's highest level of completed education?

- ❑ Elementary School only (grades 1-8)
- ❑ Some high school, but did not finish (grades 9-11)
- ❑ Completed high school or GED (high school graduate)
- ❑ Some college, but have not completed a degree
- ❑ Two-year college degree / A.A / A.S.
- ❑ Four-year college degree / B.A. / B.S.
- ❑ Some graduate work but have not completed a degree
- ❑ Completed a Master's degree or professional degree (e.g., ARNP)
- ❑ Completed a Ph.D., law degree, M.D., or similar advanced professional degree

Biological mother's current employment status?

❑ Employed full time ❑ Employed part time ❑ Unemployed / Looking for work ❑ Homemaker ❑ Retired

If employed full or part time, what is biological mother's occupation or type of work? _____

_____

Has the biological mother ever sought psychiatric treatment? ❑ No ❑ Yes

If yes, please explain the purpose: _____

Has the biological mother ever had treatment or counseling for alcohol or drug use? ❑ No ❑ Yes

If yes, please explain: _____

Does/has anyone on the biological mother's side of the family…

Take psychiatric medications? ❑ No ❑ Yes If yes, who, what medications, and why? _____

_____

Ever been hospitalized for a psychiatric problem? ❑ No ❑ Yes If yes, who and why? _____

_____

Ever been hospitalized for alcoholism or drug abuse? ❑ No ❑ Yes If yes, who and why? _____

_____

Ever attempted suicide? ❑ No ❑ Yes If yes, who? _____

Ever committed/completed suicide? ❑ No ❑ Yes If yes, who? _____

**Biological Father**

Biological father's current age: _____

If deceased, age at death and cause of death: _____

Biological father's race/ethnicity:

❑ American Indian ❑ Alaska Native ❑ Asian ❑ Black / African American ❑ Hispanic / Latino ❑ Middle Eastern Indian

❑ Native Hawaiian / Other Pacific Islander ❑ Other _____ ❑ Unknown

Biological father's highest level of completed education?

- ❑ Elementary School only (grades 1-8)
- ❑ Some high school, but did not finish (grades 9-11)
- ❑ Completed high school or GED (high school graduate)
- ❑ Some college, but have not completed a degree
- ❑ Two-year college degree / A.A / A.S.
- ❑ Four-year college degree / B.A. / B.S.
- ❑ Some graduate work but have not completed a degree
- ❑ Completed a Master's degree or professional degree (e.g., ARNP)
- ❑ Completed a Ph.D., law degree, M.D., or similar advanced professional degree



5100-0055
(01/2019)

Banner Health

## NEW PATIENT MEDICAL HISTORY
## BEHAVIORAL HEALTH PEDIATRIC

Patient Name: _____ Date of Birth: _____

Biological father's current employment status?

❑ Employed full time ❑ Employed part time ❑ Unemployed / Looking for work ❑ Homemaker ❑ Retired

If employed full or part time, what is biological father's occupation or type of work? _____

_____

Has the biological father ever sought psychiatric treatment? ❑ No ❑ Yes

If yes, please explain the purpose: _____

Has the biological father ever had treatment or counseling for alcohol or drug use? ❑ No ❑ Yes

If yes, please explain: _____

Does/has anyone on the biological father's side of the family:

Take psychiatric medications? ❑ No ❑ Yes If yes, who, what medications, and why? _____

_____

Ever been hospitalized for a psychiatric problem? ❑ No ❑ Yes If yes, who and why? _____

_____

Ever been hospitalized for alcoholism or drug abuse? ❑ No ❑ Yes If yes, who and why? _____

_____

Ever attempted suicide? ❑ No ❑ Yes If yes, who? _____

Ever committed/completed suicide? ❑ No ❑ Yes If yes, who? _____

**If your child is <u>NOT</u> adopted, please <u>SKIP</u> this section, and resume at "Family Medical History"**

### Non-Biological/Adoptive Parents

How long has this child been with you? _____

Are you related to the child (grandparent, aunt/uncle)? ❑ No ❑ Yes

If yes, how related? _____

**Non-Biological Mother** In the following questions, "mother" refers to the foster or adoptive mother

Mother's current age: _____

If deceased, age at death and cause of death: _____

Mother's race/ethnicity:

❑ American Indian ❑ Alaska Native ❑ Asian ❑ Black / African American ❑ Hispanic / Latino ❑ Middle Eastern Indian
❑ Native Hawaiian / Other Pacific Islander ❑ Other _____ ❑ Unknown

Mother's highest level of completed education?

❑ Elementary School only (grades 1-8)
❑ Some high school, but did not finish (grades 9-11)
❑ Completed high school or GED (high school graduate)
❑ Some college, but have not completed a degree
❑ Two-year college degree / A.A / A.S.
❑ Four-year college degree / B.A. / B.S.
❑ Some graduate work but have not completed a degree
❑ Completed a Master's degree or professional degree (e.g., ARNP)
❑ Completed a Ph.D., law degree, M.D., or similar advanced professional degree

Banner Health

## NEW PATIENT MEDICAL HISTORY
## BEHAVIORAL HEALTH PEDIATRIC

Patient Name: _____ Date of Birth: _____

Mother's current employment status?
❑ Employed full time ❑ Employed part time ❑ Unemployed / Looking for work ❑ Homemaker ❑ Retired
If employed full or part time, what is mother's occupation or type of work? _____

_____

Please describe the medical problems the mother may have: _____

_____

Please describe any behavioral/emotional problems the mother may have: _____
Has the mother ever sought psychiatric treatment? ❑ No ❑ Yes
If yes, please explain the purpose: _____
Has the mother ever had treatment or counseling for alcohol or drug use? ❑ No ❑ Yes
If yes, please explain: _____
Does/has anyone on the mother's side of the family…
Take psychiatric medications? ❑ No ❑ Yes If yes, who, what medications, and why? _____

_____

Ever been hospitalized for a psychiatric problem? ❑ No ❑ Yes
If yes, who and why? _____
Ever been hospitalized for alcoholism or drug abuse? ❑ No ❑ Yes
If yes, who and why? _____
Ever attempted suicide? ❑ No ❑ Yes
If yes, who? _____
Ever committed/completed suicide? ❑ No ❑ Yes
If yes, who? _____

**Non-Biological Father.** In the following questions, "father" refers to the foster or adoptive father.
Father's current age: _____
If deceased, age at death and cause of death: _____

Father's race/ethnicity:
❑ American Indian ❑ Alaska Native ❑ Asian ❑ Black / African American ❑ Hispanic / Latino ❑ Middle Eastern Indian
❑ Native Hawaiian / Other Pacific Islander ❑ Other _____ ❑ Unknown

Father's highest level of completed education?
❑ Elementary School only (grades 1-8)
❑ Some high school, but did not finish (grades 9-11)
❑ Completed high school or GED (high school graduate)
❑ Some college, but have not completed a degree
❑ Two-year college degree / A.A / A.S.
❑ Four-year college degree / B.A. / B.S.
❑ Some graduate work but have not completed a degree
❑ Completed a Master's degree or professional degree (e.g., ARNP)
❑ Completed a Ph.D., law degree, M.D., or similar advanced professional degree

Father's current employment status?
❑ Employed full time ❑ Employed part time ❑ Unemployed / Looking for work ❑ Homemaker ❑ Retired
If employed full or part time, what is father's occupation or type of work? _____
Please describe the medical problems the father may have: _____

_____


5100-0055
(01/2019)

Banner Health

## NEW PATIENT MEDICAL HISTORY
## BEHAVIORAL HEALTH PEDIATRIC

Patient Name: _____ Date of Birth: _____

Please describe any behavioral/emotional problems the father may have: _____

_____

Has the father ever sought psychiatric treatment? ❑ No ❑ Yes

If yes, please explain the purpose: _____

_____

Has the father ever had treatment or counseling for alcohol or drug use? ❑ No ❑ Yes

If yes, please explain: _____

_____

Does/has anyone on the father's side of the family:

Take psychiatric medications? ❑ No ❑ Yes If yes, who, what medications, and why? _____

_____

Ever been hospitalized for a psychiatric problem? ❑ No ❑ Yes

If yes, who and why? _____

Ever been hospitalized for alcoholism or drug abuse? ❑ No ❑ Yes

If yes, who and why? _____

Ever attempted suicide? ❑ No ❑ Yes

If yes, who? _____

Ever committed/completed suicide? ❑ No ❑ Yes

If yes, who? _____

### Family Medical History

Does anyone in your child's BIOLOGICAL FAMILY have a history of:

| | |
|---|---|
| Sudden or unexplained death in someone young? | ❑ No ❑ Yes |
| Sudden cardiac death or "heart attack" in members younger than 35 years of age? | ❑ No ❑ Yes |
| Sudden death during exercise? | ❑ No ❑ Yes |
| Cardiac arrhythmias? | ❑ No ❑ Yes |
| Hypertrophic cardiomyopathy or other cardiomyopathy? | ❑ No ❑ Yes |
| Long QT syndrome, short-QT syndrome or Brugada syndrome? | ❑ No ❑ Yes |
| Wolff-Parkinson-White syndrome? | ❑ No ❑ Yes |
| Marfan syndrome? | ❑ No ❑ Yes |
| Celiac disease? | ❑ No ❑ Yes |

### Caregiver Stress Level

**To Be Filled Out By The Main Caregiver.** Answer these questions about YOUR level of stress.

| | Not at all | A little bit | Moderate amount | A good deal | Very much |
|---|---|---|---|---|---|
| Stress means a situation in which a person feels tense, restless, nervous or anxious, or is unable to sleep at night because his/her mind is troubled all the time. How much do you feel this kind of stress these days (at the present time)? | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | ❑ 5 |



5100-0055
(01/2019)

Banner Health

## NEW PATIENT MEDICAL HISTORY
## BEHAVIORAL HEALTH PEDIATRIC

Patient Name: _____ Date of Birth: _____

| | No stress | | | | | | Extreme stress |
|---|---|---|---|---|---|---|---|
| In the past year, how would you rate the amount of stress you have in your life, at home and at work? | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | ❑ 5 | ❑ 6 |

These questions ask about your feelings and thoughts during the PAST TWO WEEKS (14 days). For each, please indicate how often you felt or thought a certain way.

| | Never | Almost never | Some times | Fairly often | Very often |
|---|---|---|---|---|---|
| How often have you felt that you were unable to control the important things in your life? | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 |
| How often have you felt confident about your ability to handle your personal problems? | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 |
| How often have you felt that things were going your way? | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 |
| How often have you felt difficulties were piling up so high that you could not overcome them? | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 |

| | I can shake off stress | | | | | | Stress eats away at me |
|---|---|---|---|---|---|---|---|
| In general, how would you rate your ability to handle stress? | ❑ 0 | ❑ 1 | ❑ 2 | ❑ 3 | ❑ 4 | ❑ 5 | ❑ 6 |

### Child's Developmental History

### Prenatal History and Mother's Health during Pregnancy

Was the pregnancy with this child: ❑ Planned ❑ Unplanned ❑ Unknown

During pregnancy, did mother… *Please check all that apply*

❑ Smoke cigarettes ❑ Drink alcohol ❑ Use medical marijuana ❑ Use illegal drugs ❑ Unknown

Was mother depressed during pregnancy? ❑ No ❑ Yes ❑ Unknown

If yes, how long did it last? _____

Was mother depressed after pregnancy? ❑ No ❑ Yes ❑ Unknown

If yes, how long did it last? _____

Was father depressed after pregnancy? ❑ No ❑ Yes ❑ Unknown

If yes, how long did it last? _____

### Birth and Postnatal Period

Where was this child born? _____

City State Country



5100-0055
(01/2019)

Banner Health

## NEW PATIENT MEDICAL HISTORY
## BEHAVIORAL HEALTH PEDIATRIC

Patient Name: _____ Date of Birth: _____

Child's primary caregiver in the first year: ❑ Mother ❑ Father ❑ Other: _____
Child's primary caregiver after the first year: ❑ Mother ❑ Father ❑ Other: _____

### Developmental History

If you can recall, please record the age at which your child reached the following developmental milestones. If you cannot recall the age, please check the box that best describes when the milestones were reached.

| | Age | Best recollection, if exact age is not recalled | | |
|---|---|---|---|---|
| Sat without support | _____ | ❑ Early | ❑ Normal | ❑ Late |
| Crawled | _____ | ❑ Early | ❑ Normal | ❑ Late |
| Stood without support | _____ | ❑ Early | ❑ Normal | ❑ Late |
| Walked without assistance | _____ | ❑ Early | ❑ Normal | ❑ Late |
| Bowel trained | _____ | ❑ Early | ❑ Normal | ❑ Late |
| Bladder trained, day | _____ | ❑ Early | ❑ Normal | ❑ Late |
| Bladder trained, night | _____ | ❑ Early | ❑ Normal | ❑ Late |
| Tied shoelaces | _____ | ❑ Early | ❑ Normal | ❑ Late |
| Rode bicycle | _____ | ❑ Early | ❑ Normal | ❑ Late |

Did your child ever receive Early Intervention? ❑ No ❑ Yes
If yes, please describe: _____

### Language Development

Please indicate the child's age when the following language milestones were reached. (Beside each question is the age most children reach the milestone. They may not be the same for your child).

- Several words besides mama and dada (1 year) _____
- Naming several objects: ball, cup, etc. (15 months) _____
- Three words together: subject, verb, object (2 years) _____

When compared to peers, was there any problem with vocabulary, articulation, and comprehension?
❑ No ❑ Yes ❑ If yes, describe: _____
Has your child ever received speech therapy? ❑ No ❑ Yes If yes, at what age? _____


5100-0055
(01/2019)

Banner Health

## NEW PATIENT MEDICAL HISTORY
## BEHAVIORAL HEALTH PEDIATRIC

Patient Name: _____ Date of Birth: _____

### Social Development

Please indicate the child's age when the following social milestones were reached. (Beside each question is the age most children reach the milestone. They may not be the same for your child).

- Smiled (2 mo) _____
- Shy with strangers (6 - 10 mo) _____
- Separates from parent easily (2-3 yrs) _____
- Cooperative play with others (4 yrs) _____

Were there problems with attachment with mother or father? ❑ No ❑ Yes

If yes, describe: _____

Were there problems when the child was first separating from home, for example when starting daycare/preschool/ kindergarten/first grade? ❑ No ❑ Yes

If yes, describe: _____

Problems in relationships with other family members? (Include siblings) ❑ No ❑ Yes

If yes, describe: _____

Problems in past peer interactions. That is, has the child had difficulty getting along with friends?

❑ No ❑ Yes ❑ If yes, describe: _____

#### Friendships

Does your child get along with other children currently? ❑ No ❑ Yes

Does your child get invited for sleepovers or birthday parties? ❑ No ❑ Yes

Does your child attend sleepovers or birthday parties? ❑ No ❑ Yes

Does your child have a best friend? ❑ No ❑ Yes

#### Animals

Does your child have any fears of animals? ❑ No ❑ Yes

Does your child have a pet now or had a pet in the past? ❑ No ❑ Yes Pet's name _____

### Emotional Development

Each child is BORN with a natural form of interacting with people, places, and things. This is called their "temperament." Of the following, how would you describe your child's temperament?

- ❑ **Easy or flexible** children are generally calm, happy, regular in sleeping and eating habits, adaptable, and not easily upset. Because of their easy style, parents need to set aside special times to talk about the child's frustrations and hurts because he or she won't demand or ask for it.
- ❑ **Difficult, active, or feisty** children are often fussy, irregular in feeding and sleeping habits, fearful of new people and situations, easily upset by noise and commotion, high strung, and intense in their reactions.
- ❑ **Slow to warm up or cautious** children are relatively inactive and fussy, tend to withdraw or to react negatively to new situations, but their reactions gradually become more positive with continuous exposure.

Does your child have fears/phobias (the dark, snakes, clowns, etc.)

❑ No ❑ Yes ❑ If yes, describe: _____

Does your child have special objects (blanket, dolls, etc.)

❑ No ❑ Yes ❑ If yes, describe: _____



5100-0055
(01/2019)

Banner Health

# NEW PATIENT MEDICAL HISTORY
# BEHAVIORAL HEALTH PEDIATRIC

Patient Name: _____ Date of Birth: _____

## Housing and Household

**Child's Housing.** Which of the following best describes your child's current housing situation?

❑ Own single/multiple family home
❑ Rented apartment
❑ Rented house
❑ Subsidized housing (e.g., HUD)
❑ Boarding school
❑ Group home
❑ Shelter
❑ Residential treatment
❑ Homeless

What is the primary language spoken in the home? _____

Do you have any concerns about the security or safety of the home or neighborhood?

❑ No ❑ Yes If yes, please describe: _____

For this current year, what do you expect your family income from all sources before taxes to be?

❑ Under $25,000
❑ $25,000 - $39,999
❑ $40,000 - $49,999
❑ $50,000 - $74,999
❑ $75,000 - $99,999
❑ $100,000 - $124,999
❑ $125,000 - $149,999
❑ Over $150,000 Prefer not to disclose
❑ Prefer not to disclose

## Legal

Has Child Protective Services ever been involved in your family's life? ❑ No ❑ Yes

If yes, please describe: _____

_____

Does a parent or child have a history with the legal system? ❑ No ❑ Yes

If yes, please describe: _____

_____

## Family Religious/Spiritual Beliefs

Does your family attend religious services? ❑ No ❑ Yes If yes, please describe: _____

_____

Is your child involved in a youth group through your family's religion? ❑ No ❑ Yes

If yes, please describe: _____

What religious/spiritual dimensions should we consider in planning your child's care, if any? _____

_____

## Discipline

What disciplinary techniques do you use with your child? _____

_____

Have these techniques been effective? ❑ No ❑ Yes

What methods of discipline seem to work best with the child? _____

_____



5100-0055
(01/2019)

Banner Health

# NEW PATIENT MEDICAL HISTORY
# BEHAVIORAL HEALTH PEDIATRIC

Patient Name: _____ Date of Birth: _____

## School History

Does the child currently have a learning disability or a history of a learning disability? ❑ No ❑ Yes
If yes, please describe: _____

_____

_____

Comments from teachers: _____

_____

_____

Other school/educational concerns: _____

_____

Does the child have an **Individualized Education Program** (IEP)? ❑ No ❑ Yes
If yes, what are the accommodations? _____

_____

Are you satisfied with the accommodations? ❑ No ❑ Yes
Does the child have a **504 plan**? ❑ No ❑ Yes
If yes, what are the accommodations? _____

_____

Are you satisfied with the accommodations? ❑ No ❑ Yes

## ADDITIONAL INFORMATION

Is there any additional information you would like us to know or which you believe will be helpful to better understand your child?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____



5100-0055
(01/2019)