Kids Health Alliance Behavior History

Name: Date: Form filled out by : mom, dad, guardian

1. Please √ if your child has any of the following issues. □ Hyper □ cannot focus □ cannot complete home work or assignments □ impulsive □ forgetful □ disorganized □ doesn't listen □ defiant □ talks back □ lies □ steals □ gets into physical fights □ other problems not mentioned here :

2. Are there severe and recurrent anger outbursts that are grossly out of proportion in intensity or duration to the situation ? ❒No ❒ Yes

If yes , do they occur, on average, three or more times each week for 1 year or more ? ❒No ❒ Yes.

Between outbursts is mood persistently irritable or angry (most of the day and nearly every day) ? ❒No ❒ Yes

Are there 3 or more consecutive months intervals without symptoms when mood is stable ? ❒No ❒ Yes

3. How long the behavior problems have been present? ❒_____Months ❒_____years ❒ since age_____ ❒unknown

4. Problems are present at ❒ home ❒school ❒ other places **5**. Does s/he have any sleep problems? ❒No ❒ Yes

Goes to bed at :_____ pm. Wakes up at:_____ am. Difficulty getting up ? ❒No ❒ Yes . TV in bedroom ? ❒ No ❒ Yes

6. Does s/he have any symptoms in any of the following body system areas (ROS) now? **Please circle:**

Body system	yes	no	Body system	yes	no	Body system	yes	no
Constitutional (fever, fatigue, weight loss, ↓ appetite)			ENT (snoring, apnea, daytime sleepiness)			Allergy/immunologic (seasonal or year round allergies, immune disorders)		
Eyes			Respiratory			Skin (eczema, unusual birthmarks)		
Endo (under or overacting thyroid)			GI (stomach aches, vomiting ,diarrhea, soiling)			Neurologic (headaches ,blurry vision, tics ,starring episodes, unexplained seizures)		
Cardiovascular (palpitations, exertion chest pain, or fainting on exertion)			GU (bedwetting)			psychiatric (depression, elated mood , anxiety, fears ,phobias, delusions, hallucinations)		

7. Does s/he have any significant birth or past medical history like Prematurity ? Congenital heart disease? Thyroid disease ? (Circle) Yes ❒ No ❒

8. Does s/he have any Motor delay? Chromosomal abnormalities? Cerebral palsy? Seizure ? Lead poisoning? Anemia ? (Circle) Yes ❒ No ❒

9. Does s/he have Speech delay ? Sensory Integration dysfunction? Autism, PDD or Asperger syndrome ? (Circle) Yes ❒ No ❒

10.Has s/he been ever evaluated or diagnosed with ADHD or behavior or psychiatric problems? Yes ❒ No ❒

if yes, was s/he prescribed any medication? Yes ❒ No ❒

11. Is he/she taking any medication now ? Yes ❒ No ❒ If Yes please give details below. **12**. Allergies to any medication? Yes ❒ No ❒

Name	Dose	When started	Helping (helped)	Taking now?

13. Does anybody in your family (or biological mom's or dad's side of the family) have any of the following conditions?

Condition	yes	no	Condition	yes	no	Condition	yes	no
ADHD			Depression			Cardiomyopathy		
Anxiety disorder			Drugs/Alcohol dependence			Long QT syndrome		
Bipolar disorder			Learning disability			Sudden death in early age ≤ 40		
Schizophrenia			Suicide			Seizures		

14. Does your child's behavior remind you any relative in particular? Yes ❒ No ❒, **if yes who?** _____

15. Has s/he ever been removed from home (been in foster care) ? Yes ❒ No ❒,**if yes please give details :**_____

16. Are biological parents together ? Yes ❒ No ❒ ,**if no please describe present living arrangement**:_____

If you have answered Yes to any question please use the reverse side and elaborate against corresponding number.

Revised 03/13/2018.