

Physicians to Children, Inc.

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FAMILY DATA: (To be completed by parent(s))

Date: _____

Child's Name: _____ Adopted: ☐ Yes ☐ No ☐ Birth Date: _____

Home Address: _____ Home Phone: _____

School: _____ Grade: _____ School Phone: _____

Father's Name: _____ Age: _____ Education: _____

Employment: _____

Mother's Name: _____ Age: _____ Education: _____

Employment: _____

Other children in home:

Name and age: _____ Name and age: _____

Name and age: _____ Name and age: _____

Other relatives or persons living in the home: _____

Check appropriate items below:

(Our, My) reason for bringing the child in today is ☐ routine physical checkup ☐ physical problems

☐ speech problems ☐ poor school work ☐ behavior problems ☐ not doing well at home or school.

The problem has been going on for ☐ weeks ☐ months ☐ a year or more.

The child lives with ☐ both parents ☐ stepfather ☐ stepmother ☐ other

☐ Father ☐ Mother ☐ Neither ☐ Both had similar troubles

The child ☐ disrupts ☐ gets along with family.

The child has mostly been a source of ☐ pride ☐ worry ☐ friction for the family.

Parents Complete This:

The parents ☐ agree ☐ disagree on how to discipline child.

Discipline has been ☐ strict ☐ lenient ☐ inconsistent ☐ all of these.

Marital troubles are ☐ mild ☐ moderate ☐ severe.

Parents have problems of ☐ alcoholism ☐ chronic disease ☐ mental illness ☐ none of these.

Other children in the home have problems with ☐ school behavior ☐ grades ☐ illness ☐ emotional adjustment.

PREGNANCY HISTORY:

Did you have prenatal care with this child's pregnancy? ☐ Yes ☐ No

Did you have any medical problems or complications during the pregnancy? ☐ Yes ☐ No

If yes, explain: _____

BIRTH HISTORY:

How many hours from first contractions to birth? _____

Did you have a C-Section? ☐ Yes ☐ No If yes, why? _____

Was the delivery unusual in any way? ☐ Yes ☐ No If yes, explain: _____

Was this a twin delivery? ☐ Yes ☐ No

Was the baby born on time? ☐ Yes ☐ No If no, explain: _____

Did the baby: Cry quickly	<input type="checkbox"/> Yes <input type="checkbox"/> No
Look pink	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have breathing problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have cord around neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Need oxygen	<input type="checkbox"/> Yes <input type="checkbox"/> No

What was the birth weight? _____

How many days before you took the baby home? _____

Parents Complete This:

MEDICAL HISTORY OF CHILD

Does your child have any chronic medical problems? _____

Has your child ever been involved in an accident of any sort, or had an injury to his/her head? _____

Has your child had any operations? _____

Regular medicines the child takes: _____

Allergies: _____

DEVELOPMENTAL HISTORY OF CHILD (As best you remember)

Age head help up _____ Age rolled over _____ Age first smiled _____

Age crawled _____ Age sat _____ Age pulled up _____

Age walked alone _____ Age said 4-10 words _____ Age used sentences _____

Potty-trained age _____ Age helped with dressing _____ Right or left-handed _____

PARENTAL SCHOOL HISTORY (Circle the correct answer)

According to school, the child's IQ is (Average, Below Average, Above Average, I don't know)

Since first grade (if applicable), school personnel have reported (No serious problems, Problems with behavior, Speech problems, Reading problems, Writing problems, Spelling problems, Math problems)

Child has (Been in special education class, Failed a grade, Been tutored, Made satisfactory grades)

School personnel have reported through the years that your child (Adjusts to other children, Doesn't adjust)

Your child (Likes school, Hates school, Is indifferent)

Behavior Rating Scale

Parent Copy

Please check in the appropriate column	Rare	Sometimes	Most of the Time
1. Often fidgets with hands or feet, or squirms in seat (in adolescents may be limited to just feeling restless)			
2. Has difficulty remaining seated when required to do so.			
3. Is easily distracted by extraneous stimuli.			
4. Has difficulty waiting turn in games or group situations.			
5. Often blurts out answers to questions before they have been completed.			
6. Has difficulty following through on instructions from others. (e.g. fails to finish chores)			
7. Has difficulty sustaining attention in tasks or play activities.			
8. Often shifts from one uncompleted activity to another.			
9. Has difficulty playing quietly.			
10. Often talks excessively.			
11. Often interrupts or intrudes on others (e.g. butts into other children's games)			
12. Often does not seem to listen to what is being said to him/her.			
13. Often loses things necessary for tasks or activities at school or at home. (toys, pencils, books)			
14. Often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill seeking. (e.g. runs into street without looking)			

How old was your child when his/her behavior became a problem in your view? _____