Twin City Pediatrics
Behavioral Questionnaire for Ages 0-6

Patient Name: ________________
Patient Date of Birth: ___________

Demographic Information:

Parent #1: ___________ Parent #2: _____________
Occupation: ___________ Occupation: _____________

Who lives in your home?
____
____

Other Children in or out of the Home:

Name	Date of Birth	Sex	Relationship to Child	School and Grade

Behavioral Concerns:

List/Describe problems and age of onset: ____________________________________
____
____
____
____

What have you done to cope with these problems? (include details of Behavioral techniques, Medications, or Counseling): ____________________________________
____
____
____
____

What would you like this evaluation to accomplish? ____________________________
____
____
____
____
____

List previous examination and evaluations of your child (including physical, hearing, psychological testing, speech, language, reading, psychiatric and neurological evaluations, etc) By Whom and Date: ____________________________________
____
____
____
____
____

Health and Medical Information

Pregnancy/Labor/Delivery History: Explain "yes" answers

Age of Mother when child was born: _____

	Yes	No	Comments
Is this child a twin or multiple?			
Any problems with other pregnancies?			
Any problems during this pregnancy?			
Amniocentesis or other fetal health tests (e.g., AFP)?			
Any medications prescribed?			
Gestational diabetes?			
Any problems with blood pressure of toxemia?			
Any problems with infection?			
Smoking during pregnancy?			# packs?
Drinking alcohol during pregnancy?			Amount:
Drugs taken? (marijuana, cocaine,etc.)			
Problems during labor or delivery?			
Baby Born at ______ weeks			

Newborn History: Explain "yes" answers

Birth weight: ___lbs ___oz

	Yes	No	Comments
Were there any problems at birth or as a newborn?			
Were there any birth defects or birth injuries noted?			
Needed special care or NICU/intensive care? If yes, how long?			
Jaundice or needed phototherapy?			
Very jittery as a newborn?			
Any extra stay in hospital needed?			

Development History: Explain "yes" answers

	Yes	No	Comments
Sit by 6-7 months?			
Walk by 12-15 months? Age __months			
Speak in 2 word sentences by 2 years			
Could strangers understand your child by 2-3 years of age?			

Developmental Difficulties:

	Yes	No	Not Applicable (child too young)
Night time wetting accidents? (after 5 yrs)			
Daytime wetting accidents? (after 3 yrs)			
Stool/Bowel accidents? (e.g., soiling)			
Difficulty with bedtime/falling asleep?			
Difficulty staying in bed/asleep at night?			
Difficulty waking up in the morning?			
Difficulty with feeding self?			
Difficulty with dressing?			

Health and Medical Information

	Yes	No	Comments
Serious or chronic health problems?			
Hospitalizations or surgery?			
Serious infections or illness?			
Frequent stomach aches?			
Has child ever been knocked out?			
Fainting/falling/blank spells			
Any medications taken? (give name, dose and when taken)			
Allergies to medications or other allergies? Specify type of reaction			

Child's Interests and Social Life

How does the child spend free time? ____
Special interests, hobbies, sports ____
Close friends? ____ Many friends? ____ Friendless/loner? _____
Preferences: Own age ___ Younger children ___ Older ___ Boys ___ Girls___ Adults __
Behavior with other children: Pleasant ___Cooperative ___ Irritable ___ Creative ___
Sensitive ___ Leader ___ Follower ___ Active ___ Rowdy ___ Timid ___ Sharing ___
Selfish ___ Bossy ___ Cruel ___ Helpful ___ Kind ___ Picky ___ Showoff ___
Withdrawn___Confident ___ Jealous ___ Outgoing ___ Shy ___ Tattletale ___
Other: ______________________
Describe child's relationship with adults: ____
____

Describe child's assets and successes: ____
____
____

Check the positive qualities that describe your child most of the time:

___ Happy	___Well-mannered	___Attentive	___ Cooperative
___ Hard-working	___Even tempered	___Mature	___ Generous
___ Flexible	___Dependable	___Responsive	___ Optimistic
___ Enthusiastic	___Sensitive to others	___Accepts criticism	___ Responsible
___ Confident	___Tolerant	___Compassionate	___ Considerable
___ Thoughtful	___Assertive	___Affectionate	___ Determined
___ Kind	___Patient	___Curious	___ Outgoing
___ Reliable	___Helpful	___Courteous	___ Creative

Describe nature/quality of relationship child has with each parent: ____________________
____
____

Describe nature/quality of relationship child has with siblings: ______________________
____
____

Any recent changes to home life? ____
____

What is your child's sleep schedule? (bedtime, wake up, naps, total hours of sleep)
____
____

How much screen does time your child get per day? (hours) ________________________

What grade would you give the relationship between the child's parents? (circle):

A B C D F

Family History

List any health problems/chronic illnesses of parents and siblings (e.g., heart disease, obesity, diabetes, etc) : ____
____
____
____

Does anyone in the child's immediate or extended family have the following illnesses or problems? Include parents, siblings, grandparents, aunts/uncles, cousins:

	Yes	No	Relationship to Child/Comment:
ADHD			
Anxiety			
Depression			
Bipolar Disorder			
Alcohol or Substance Abuse			
Domestic Violence/ Abuse			
Eating Disorder			
Other psychiatric problems			