

# Initial Behavior Clinic Questionnaire

Child's Name: \_\_\_\_\_

Parent/Caregiver Name(s): \_\_\_\_\_

Parent/Caregiver(s) Occupations: \_\_\_\_\_

Who all lives in the home (please include sibling's ages):

\_\_\_\_\_  
\_\_\_\_\_

Child's School: \_\_\_\_\_ City/State: \_\_\_\_\_ Grade: \_\_\_\_\_

Child's Primary Care Physician: \_\_\_\_\_

If not Nagireddi Pediatrics, LLC, please provide physician's phone #: \_\_\_\_\_

How were you referred to your appointment today? \_\_\_\_\_

What is the reason for your child's appointment today?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## EARLY BEHAVIOR INDICATORS

When did you first notice something was "not quite right?" \_\_\_\_\_

Anything "unusual" at the following ages? If so, please list below.

0-2 years old \_\_\_\_\_

3-5 years old \_\_\_\_\_

> 5 years old \_\_\_\_\_

Did your child meet his developmental milestones at an age-appropriate level? Yes No

If you answered no to the above question, please explain below:

\_\_\_\_\_  
\_\_\_\_\_

## HEALTH HISTORY

Were there any problems with mom during pregnancy with this child?

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Was your child born at 37-40 weeks gestation, or was your child born earlier than 37 weeks gestation?

Were there any problems with your child after birth?

Was your child adopted? \_\_\_\_\_ If so, at what age were they adopted? \_\_\_\_\_

Does your child have any existing/chronic medical problems or conditions? Yes    No

If yes, please list:

Has your child ever had to stay in the hospital overnight or longer? Yes    No

If yes, please include date, reason, and location for each hospitalization:

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Is there a family history of any significant medical or mental disorders? Yes    No

If yes, please explain:

Has your child had any genetic or medical testing done in the past? Yes    No

If yes, please include what type of testing, and by whom it was completed:

Has your child had any previous psychological or academic evaluations? Yes    No

If yes, please include when, by whom, and what type of evaluation was completed:

Does your child currently have a psychiatric diagnosis (i.e. ADHD, Autism, OCD, etc.)? Yes    No

If yes, please list:

Is your child/family currently seeing a counselor/psychiatrist or receiving any physical, occupational, speech, or behavioral therapies? Yes    No

If yes, please list what therapies your child is receiving and by whom:

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Does your child have an Individualized Education Plan (IEP)? Yes    No

If yes, please include what diagnosis your child has for this IEP, and when the last meeting you had with school for an IEP:

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## BEHAVIOR SYMPTOM INVENTORY

Please place an "X" next to any behaviors noted below that you think describe your child in his/her lifetime.

<p><b>Social Interaction Difficulties</b></p> <p><input type="checkbox"/> poor eye contact</p> <p><input type="checkbox"/> ignores other when called</p> <p><input type="checkbox"/> in his/her own world</p> <p><input type="checkbox"/> lack of curiosity</p> <p><input type="checkbox"/> facial expressions don't fit situation</p> <p><input type="checkbox"/> lack of ability to imitate</p> <p><input type="checkbox"/> sees the world in "black" and "white"</p> <p><input type="checkbox"/> inappropriate tears/laughter/emotions</p> <p><input type="checkbox"/> does not understand other's feelings</p> <p><input type="checkbox"/> temper tantrums</p> <p><input type="checkbox"/> inappropriately anxious/fearful</p> <p><input type="checkbox"/> hates crowds</p> <p><input type="checkbox"/> more comfortable around adults</p> <p><input type="checkbox"/> difficulty with peer relationships</p>	<p><b>Motor Skills</b></p> <p><input type="checkbox"/> holds a pencil "funny"</p> <p><input type="checkbox"/> difficulty taking notes/writing</p> <p><input type="checkbox"/> walks on tip-toes</p> <p><input type="checkbox"/> clumsy body posture</p> <p><input type="checkbox"/> low muscle tone</p> <p><input type="checkbox"/> drooling or swallowing difficulties</p>
<p><b>Communication Difficulties</b></p> <p><input type="checkbox"/> loss of acquired speech</p> <p><input type="checkbox"/> produces unusual noises/gibberish</p> <p><input type="checkbox"/> voice louder than required</p> <p><input type="checkbox"/> monotonous tone</p> <p><input type="checkbox"/> no spontaneous initiation of speech</p> <p><input type="checkbox"/> repetitive language or "movie talk"</p> <p><input type="checkbox"/> uses language inappropriately</p> <p><input type="checkbox"/> does not understand nuances of speech</p> <p><input type="checkbox"/> pulls parents when wants something</p> <p><input type="checkbox"/> uses gestures to express needs, not words</p> <p><input type="checkbox"/> angry when needs not communicated and met</p>	<p><b>Sensory</b></p> <p><input type="checkbox"/> sensitive to food textures/tastes</p> <p><input type="checkbox"/> sensitive to clothing (tags, tightness)</p> <p><input type="checkbox"/> sensitive to bright lights</p> <p><input type="checkbox"/> sensitive to loud noises</p> <p><input type="checkbox"/> sensitive to certain smells</p> <p><input type="checkbox"/> does not like to be touched</p> <p><input type="checkbox"/> hand flapping</p> <p><input type="checkbox"/> head banging</p> <p><input type="checkbox"/> ignores or does not seem to feel pain</p>
<p><b>Symbolic Play</b></p> <p><input type="checkbox"/> arranges toys in rows</p> <p><input type="checkbox"/> spins objects or self</p> <p><input type="checkbox"/> smells, bangs, or licks toys</p> <p><input type="checkbox"/> obsessed with toy parts</p> <p><input type="checkbox"/> does not "pretend"</p> <p><input type="checkbox"/> difficulty stopping repetitive activity</p> <p><input type="checkbox"/> obsessed with objects/topics</p> <p><input type="checkbox"/> restricted interest (toy, movie, topic)</p> <p><input type="checkbox"/> stubborn about rituals/routines</p>	<p><b>Toileting Issues</b></p> <p><input type="checkbox"/> day time wetting</p> <p><input type="checkbox"/> enuresis (bed wetting)</p> <p><input type="checkbox"/> encopresis (stool accident/soiling)</p> <p><input type="checkbox"/> stool smearing</p>

## BEHAVIOR SYMPTOMS INVENTORY CONTINUED

Please place an "X" next to any behaviors noted below that you think describe your child in his/her lifetime.

<p><b>Short Attention Span</b></p> <p><input type="checkbox"/> lack of focus</p> <p><input type="checkbox"/> needs frequent reminders</p> <p><input type="checkbox"/> easily distracted</p>	<p><b>Impulsive</b></p> <p><input type="checkbox"/> acts without thinking</p> <p><input type="checkbox"/> trouble waiting his turn</p> <p><input type="checkbox"/> disruptive</p>
<p><b>Hyperactive</b></p> <p><input type="checkbox"/> can't sit still</p> <p><input type="checkbox"/> always on the go</p> <p><input type="checkbox"/> fidgets</p>	<p><b>Oppositional</b></p> <p><input type="checkbox"/> argues</p> <p><input type="checkbox"/> loses temper/outbursts</p> <p><input type="checkbox"/> blames others</p> <p><input type="checkbox"/> intense</p>
<p><b>Anxious</b></p> <p><input type="checkbox"/> cries frequently/easily</p> <p><input type="checkbox"/> fearful of new situations</p> <p><input type="checkbox"/> panic/worries over small things</p>	<p><b>Conduct Disorder</b></p> <p><input type="checkbox"/> lies, steals</p> <p><input type="checkbox"/> often gets into fights</p> <p><input type="checkbox"/> cruel to people/animals</p> <p><input type="checkbox"/> self injury</p> <p><input type="checkbox"/> fire setting</p>
<p><b>Adjustment Problems</b></p> <p><input type="checkbox"/> has trouble with new circumstances or situations</p>	<p><b>Depression</b></p> <p><input type="checkbox"/> often seems sad</p> <p><input type="checkbox"/> cries often</p> <p><input type="checkbox"/> pessimistic</p>

## ADDITIONAL AREAS OF CONCERN

<p><b>Learning</b></p> <p><input type="checkbox"/> memory</p> <p><input type="checkbox"/> math</p> <p><input type="checkbox"/> spelling</p> <p><input type="checkbox"/> attention</p> <p><input type="checkbox"/> distractibility</p> <p><input type="checkbox"/> motivation</p> <p><input type="checkbox"/> expressive language (written and/or verbal)</p> <p><input type="checkbox"/> receptive language (spoken and/or read)</p> <p><input type="checkbox"/> motor skills</p>	<p><b>School</b></p> <p><input type="checkbox"/> absenteeism</p> <p><input type="checkbox"/> class work completion</p> <p><input type="checkbox"/> homework completion</p> <p><input type="checkbox"/> inconsistent performance</p> <p><input type="checkbox"/> test taking</p> <p><input type="checkbox"/> unhappy at school</p>	<p><b>Social</b></p> <p><input type="checkbox"/> anger control</p> <p><input type="checkbox"/> disobedience</p> <p><input type="checkbox"/> disruptive behavior</p> <p><input type="checkbox"/> immaturity (compared to peers)</p> <p><input type="checkbox"/> peer relationships</p> <p><input type="checkbox"/> risk-taking</p> <p><input type="checkbox"/> poor self-esteem</p> <p><input type="checkbox"/> hyperactivity</p>
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**FURTHER AREAS OF CONCERN**

If there are further areas of concern that were not covered in the above checklists, or you would like to describe them in more detail, please feel free to do so below.

**Family:**

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**Social Relationships:**

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**Academics/School/Learning:**

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**Speech/Language/Communication:**

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**Sleep:**

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**Appetite/Eating:**

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**Sensory (hearing, vision, touch/texture, smell, taste):**

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**Toileting:**

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**Rituals/Routines/Obsessions:**

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**Other:**

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**What are your child's strengths?**

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**What does your child enjoy doing?**

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**CURRENT MEDICATIONS**

Please list all medications that your child takes currently. Please include over the counter medications and supplements/vitamins.

Medication	Dose	When given	Prescribing Doctor