wasatch pediatrics

Wasatch Pediatrics Farmington
491 W, Bourne Circle
Farmington ,UT
801-939-9111

Patient History and Assessment

Please fill out this form to the best of your knowledge. If some questions are not applicable to your child. Write N/A. If you wish to make additional comments, please write on the back or attach a separate sheet.

General Information

Child's Name_______________________________________ D.O.B.______________________ Today's Date: ___________________
First *Last*

Form Completed by:_______________________________________ Relationship to child: __________________________________

Religion/ Spiritual Affiliation: ________________________________ Ethnicity/ Cultural identity: ____________________________

Name of child's current school:____ School District: _______________________________

School Telephone:_______________________________ Grade: ________ Teacher: _______________________________________

Current Concerns

What is the main reason you are seeking this visit? ____

____

How long has your child had these problems? Or how long have you been concerned about your child's difficulties?

____

Where does your child exhibit these problems? (check all that apply)

□ Home □ School □ Other specify: ______________________________

Family Status

Mother's History:

Mother's name: ____ Home phone: ___________________
First Middle Last

Work/ Cell phone: ____________________/______________________ Occupation:___________________________________

Education/Highest grade completed:____________________________

Father's History:

Father's name: ____ Home phone: ___________________
First Middle Last

Work/ Cell phone: ____________________/______________________ Occupation:__________________________________

Education/Highest grade completed:____________________________

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Family Status (continued)

Marital Status of Parents:

☐ Married for _______years ☐ Never Married ☐ Separated ☐ Divorced ☐ Widowed

Child currently lives with: (please check all that apply and give details)

☐ Natural Mother ☐ Natural Father ☐ Stepmother ☐ Stepfather

☐ Adoptive Mother ☐ Adoptive Father ☐ Foster Mother ☐ Foster Father

☐ Grandmother ☐ Grandfather ☐ Other / Details____

____

Family Stressors or Events

Have any of the following events occurred within the past 1-2 years:

☐ Parents divorced or separated ☐ Parent changed job ☐ New baby at home ☐ Child changed schools

☐ Family accident or illnes ☐ Death in family ☐ Conflict in family ☐ Child repeated a grade

☐ Family financial problems ☐ Family moved ☐ Family changes ☐ Other:______________

Family History

Has anyone in your family experienced the following :

Medical Condition	Relationship to the child	Medical Condition	Relationship to the child
☐ Learning Problems	____________________	☐ Mental Retardation	_____________________
☐ ADHD/ ADD	____________________	☐ Tic Disorders	_____________________
☐ Autism/ PDD/Asperger's	____________________	☐ Seizure Disorders	_____________________
☐ Depression	____________________	☐ Genetic Syndromes	_____________________
☐ Anxiety	____________________	☐ Muscle/Motor Problems	_____________________
☐ Bipolar Disorder (Manic Depression)	____________________	☐ Endocrine Problems (Hormonal Problems)	_____________________
☐ Obsessive Compulsive Disorder	____________________	☐ Alcohol/Substance abuse	_____________________
☐ Schizophrenia	____________________	☐ Other	_____________________

Are there any other relevant family concerns?

Please Describe:____

____

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Birth History

Was the baby on time? ☐ Yes ☐ No If No, was he/ she ☐ Early ☐ Late By how many weeks? ___________

Birth weight _________________________

Age of mother at birth:_________________ Age of father at birth? __________________

Any complications in the newborn/ infant period? ____

____

Developmental Concerns

Please describe any developmental concerns you may have for your child:

____

Pertinent Past Medical History

Please check which of the following you child has had and note the age, frequency and any complications below:

Yes	No		Yes	No	
☐	☐	Hospitalizations	☐	☐	Vision problems (date of last exam:____)
☐	☐	Surgery	☐	☐	Hearing problems (date of last exam:____)
☐	☐	Head Trauma	☐	☐	Stomach aches
☐	☐	Loss of consciousness	☐	☐	Excessive vomiting
☐	☐	Seizures	☐	☐	Pica (eating non food items)
☐	☐	Tics (motor/ vocal)	☐	☐	Gastrointestinal difficulties
☐	☐	Headaches (migraines: Y / N)	☐	☐	Chronic ear infections (PE tubes Y / N)

Details from above:____

____

Current & Past Medications

Medication	Dosage	Frequency	Start date/ End date	Reason for discontinuing

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Social

How many close friends does your child have? _______

Does he/she have a best friend? ☐ Yes ☐ No (If yes, how long have they been friends?_________)

How easily does your child make friends?

☐ Better than average ☐ Average ☐ Worse than average (explain: ____)

How well does you child get along with friends?

☐ Better than average ☐ Average ☐ Worse than average (explain: ____)

Does you child get along best with: ☐ Older children ☐ Children the same age ☐ Younger children

Is your child teased/ bullied? ☐ Yes ☐ No (If yes, for what: ___________________________; how often ___________)

Does you child tease or bully others? ☐ Yes ☐ No (if yes, how: ____________________________; how often ___________)

Is your child physically or verbally aggressive with their peers or siblings? ☐ Yes ☐ No (if yes how often: _______________)

Sleep Habits

Do you feel your child has sleep problems? (Describe)____

Where does your child sleep?

☐ Own bedroom ☐ Shared bedroom (with whom?_________________)

☐ Room other than a bedroom (describe:____________________) ☐ In parents bedroom

What time is your child's bedtime? ____________________ **What time does your child fall asleep?** ____________________

How many total hours sleep does your child currently get each night? ______________ Does your child nap? ☐ Yes ☐ No

Does your child currently experience any of the following? Check all that apply

☐ Snoring/ Mouth Breathing ☐ Restlessness

☐ Difficulty falling asleep? (how long does it take?__________) ☐ Waking in the night? (how many times?__________)

☐ Nightmares (how often?_____________________________) ☐ Night Terrors (how often?______________________)

☐ Sleep Walking/ Talking (how often?____________________) ☐ Other______________________________________

Personal

What are you child's hobbies and interest? ____

What does you child **dislike** doing the most?____

What about your child are you most proud of? ____

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Educational History

What is you child's current class placement? ☐ Regular class ☐ Special class (specify):______________________

Has any testing been performed by the school? ☐ Yes ☐ No Date:_______________________

If so, please attach copy of the school evaluation

Briefly describe you child's current academic difficulties: ____

____

Indicate if your child has ever been in any of the following educational programs:

	Age(s) at Participation		Age(s) at Participation
☐ Early Intervention/ Headstart	____________________	☐ Life Skills Class	___________________
☐ Special Education/ IEP	____________________	☐ Speech & Language Therapy	___________________
☐ Section 504 services	____________________	☐ Occupational Therapy	___________________
☐ Resource Room Service	____________________	☐ Physical Therapy	___________________
☐ Self-Contained Class	____________________	☐ Alternative School Placement	___________________
☐ Counseling (school based)	___________________	☐ Other:____________________	___________________

Have any instructional modifications been attempted?

☐ Oral tests ☐ Extended time to complete assignments ☐ Reduced paper/pencil work

☐ Preferential seating ☐ Shortened or modified assignments ☐ Positive reinforcers/ feedback

☐ Control of distractions ☐ Behavioral modification program ☐ Peer teaching

☐ Technologic assistance (calculator, word processor, communication device)

Academic Performance

How many days has your child been absent this term? ________________

Please list your child's current grades if applicable:

Math:	_________	Language Arts:	___________	Other:	___________	________
Science:	_________	Reading:	___________	Other:	___________	________
Social Studies:	_________	Spelling:	___________	Other:	___________	________

Previously Sought Evaluations/ Services

☐ Psychiatric Evaluation ☐ Brain Scan (CT/MRI) ☐ Occupational/ Physical Therapy ☐ Psychological Counseling

☐ Neurological Exam ☐ Laboratory Tests ☐ Educational Testing ☐ Neuropsychological Assessments

☐ Genetic Testing ☐ Speech Therapy ☐ Tutoring ☐ Other______________________

What else have you tried to help your child with these problems?

____

____