Grow Up Great Pediatrics
620 Medical Drive Ste. 100
Bountiful. UT 84010
801-295-2888

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?

_____

_____