Metropolitan Pediatrics, L.L.C.

# Child & Family Information Form

| Today's Date: | / | / |

Patient Name: _____ Date of Birth: _____ / _____ / _____

Name of person completing form: _____ Relationship to patient: ❑ Parent ❑ Guardian ❑ Other: _____

Current school: _____ Grade: _____

Teacher(s): _____

## Family Information

Please answer the following questions about each adult who is involved in parenting your child, including stepparents, if applicable.

Name: _____

Age: _____ Education/Highest Grade Completed: _____

Occupation: _____

Employer: _____ Years Employed: _____

Name: _____

Age: _____ Education/Highest Grade Completed: _____

Occupation: _____

Employer: _____ Years Employed: _____

Name: _____

Age: _____ Education/Highest Grade Completed: _____

Occupation: _____

Employer: _____ Years Employed: _____

Please list all children in the family/household.

Name: _____

Age: _____ School Grade/Occupation: _____

Name: _____

Age: _____ School Grade/Occupation: _____

Name: _____

Age: _____ School Grade/Occupation: _____

Name: _____

Age: _____ School Grade/Occupation: _____

Name: _____

Age: _____ School Grade/Occupation: _____

## About Your Child

1. Please tell us a bit about the specific behaviors/difficulties that you are concerned about:

2. When did you start to have these concerns?

3. Are there any specific factors that you think may be causing or adding to your child's difficulties?

4. Please list your child's strengths—what do you admire about your child?

HIS USE ONLY

5. What skills/abilities would you like to see your child develop?

6. Has your child had any previous evaluations for these difficulties inside or outside of school? ❑ Yes ❑ No

   If yes, where and when?

7. Has your child ever received any type of mental/behavioral health treatment? ❑ Yes ❑ No

   If yes, where and when?

8. Has your child ever been prescribed medication for mood or behavioral concerns? ❑ Yes ❑ No

   If yes, where, when, what, and how much?

9. Has your child ever had any of the following concerns?

| Concern | Yes | No | If yes, please explain and provide age range. |
|---|---|---|---|
| • Colic | ❑ | ❑ | |
| • Feeding or eating problems | ❑ | ❑ | |
| • Problem with growth (height and/or weight) | ❑ | ❑ | |
| • Bedwetting (beyond 5 years old) | ❑ | ❑ | |
| • Other problems with bladder or bowel control | ❑ | ❑ | |
| • Tantrums (more than other children of same age) | ❑ | ❑ | |
| • Unwillingness to change daily | ❑ | ❑ | |
| • A time when your child had a greatly decreased need for sleep | ❑ | ❑ | |
| • A time when your child's thoughts seemed to be racing | ❑ | ❑ | |
| • Has your child ever been diagnosed by a professional with a mental/behavioral health diagnosis or developmental disability? | ❑ | ❑ | If yes, check all that apply: ❑ ADD or ADHD ❑ Depression ❑ Anxiety ❑ Behavior problems ❑ Learning disability ❑ Developmental disability ❑ Trauma |
| • Has your child had any unusual and/or traumatic family events that you feel may have impacted his/her development and current concerns? Such stressors might include the birth or death of a sibling, any death in the family, divorce, illness in the family, frequent moves and/or school changes, domestic violence or otherwise conflictual family dynamics, etc. | ❑ | ❑ | If yes, briefly describe. |

## Pregnancy, Delivery & Newborn Periods

| Concern | Yes | No | If yes, please explain. |
|---|:---:|:---:|---|
| 1. Were there any significant complications during the pregnancy? | ❑ | ❑ | |
| 2. During the pregnancy, did the mother… | | | |
| • Have to take medications? | ❑ | ❑ | |
| • Drink alcohol? | ❑ | ❑ | |
| • Take any drugs? | ❑ | ❑ | |
| 3. Were there any significant complications during the delivery? | ❑ | ❑ | |
| 4. Was the delivery a Caesarian section? | ❑ | ❑ | |
| 5. Was the baby… | | | |
| • Premature? | ❑ | ❑ | |
| • In the hospital more than 4 days? | ❑ | ❑ | |
| • Born with any birth defects? | ❑ | ❑ | |
| • Need oxygen at birth? | ❑ | ❑ | |
| • Have seizures? | ❑ | ❑ | |
| • Have an infection? | ❑ | ❑ | |

## Neurodevelopmental Skills

Please rate your child as he/she compares with other children of his/her own age on these skills.

| Skill | Better | Average | Worse |
|---|:---:|:---:|:---:|
| 1. Catching and throwing a ball | ❑ | ❑ | ❑ |
| 2. Running | ❑ | ❑ | ❑ |
| 3. Building things like models/Legos | ❑ | ❑ | ❑ |
| 4. Drawing/Art | ❑ | ❑ | ❑ |
| 5. Writing | ❑ | ❑ | ❑ |
| 6. Understanding spoken directions | ❑ | ❑ | ❑ |
| 7. Speaking clearly | ❑ | ❑ | ❑ |
| 8. Describing things | ❑ | ❑ | ❑ |
| 9. Ability to remember things | ❑ | ❑ | ❑ |

## School History

Has your child had any of the following problems in school?

| Problem | Yes | No | If yes, through what age/grade did your child have this difficulty? |
|---|:---:|:---:|---|
| 1. Speech or language problems | ❑ | ❑ | |
| 2. Reading problems | ❑ | ❑ | |
| 3. Writing problems | ❑ | ❑ | |
| 4. Spelling problems | ❑ | ❑ | |
| 5. Math problems | ❑ | ❑ | |
| 6. Other problems – Please describe. | ❑ | ❑ | |
| 7. School placement in a special classroom | ❑ | ❑ | |
| 8. Been in a resource classroom | ❑ | ❑ | |
| 9. Are you concerned with your child's ability to make or keep friendships with peers? | ❑ | ❑ | If yes, briefly describe your concerns. |

10. At what age did your child start their first school experience (this can include preschool or kindergarten, whichever was first)?

11. Please list all of the daycare settings and schools your child has attended:

## Family History & Structure

Do any family members—including the child's biological parents, grandparents, siblings, aunts, or uncles—have a history of the following conditions?

| Condition | Yes | No | If yes, comments? |
|---|---|---|---|
| 1. Hyperactivity in childhood | ❑ | ❑ | |
| 2. Behavior problems | ❑ | ❑ | |
| 3. School difficulties | ❑ | ❑ | |
| 4. Learning problems | ❑ | ❑ | |
| 5. Being kept back in school | ❑ | ❑ | |
| 6. Neurological problems (seizures, tics, Tourette's Syndrome, other) | ❑ | ❑ | |
| 7. Intellectual disability | ❑ | ❑ | |
| 8. Autism Spectrum Disorder | ❑ | ❑ | |
| 9. Other developmental disorder | ❑ | ❑ | |
| 10. Alcohol or drug abuse | ❑ | ❑ | |
| 11. Sexual or physical abuse | ❑ | ❑ | |
| 12. Mental or emotional problem such as anxiety, depression, bipolar disorder, schizophrenia, suicide, etc. | ❑ | ❑ | |
| 13. Thyroid disease | ❑ | ❑ | |
| 14. PTSD | ❑ | ❑ | |

## Behavioral Approaches at Home

What methods have been used to improve the child's behavior at home?

| Method | Yes | No | If yes, comments? |
|---|---|---|---|
| 1. Verbal reprimands | ❑ | ❑ | |
| 2. Spanking | ❑ | ❑ | |
| 3. Withdrawal of privileges | ❑ | ❑ | |
| 4. "Grounding" from social activities | ❑ | ❑ | |
| 5. Rewards | ❑ | ❑ | |
| 6. Time-outs | ❑ | ❑ | |

7. Which methods have worked best?

# Children's Sleep Habits (kids 5-12)

Patient Name: _____ Date of Birth: _____/ _____/ _____

Name of person completing form: _____ Relationship to patient: ❑ Parent ❑ Guardian ❑ Other: _____

---

**Directions:** The following statements are about your child's sleep habits and possible difficulties with sleep. Think about the **past week** in your child's life when answering the questions. If last week was unusual for a specific reason (such as your child had an ear infection and did not sleep well or the TV was broken), choose the most recent typical week.

Answer "usually" if something occurs **5 or more times** in a week.
Answer "sometimes" if it occurs **2-4 times** in a week.
Answer "rarely" if something occurs **never or 1 time** during a week.

Indicate whether or not the sleep habit is a problem by checking "Yes," "No," or "N/A" (not applicable).

**Rating Scale:**

1 = Usually (5-7)

2 = Sometimes (2-4)

3 = Rarely (0-1)

---

| Section 1 | Rating | Problem? | | |
|---|---|---|---|---|
| 1. Child goes to bed at the same time at night<br>• *Child's bedtime is ____:____ pm* | | ❑ Yes | ❑ No | ❑ N/A |
| 2. Child falls asleep alone in own bed | | ❑ Yes | ❑ No | ❑ N/A |
| 3. Child falls asleep within 20 minutes after going to bed | | ❑ Yes | ❑ No | ❑ N/A |
| 4. Child sleeps the right amount<br>• *Child's usual amount of sleep each day (naps) is _____hrs. _____mins.*<br>• *Child's usual amount of sleep each night (no naps) is _____hrs. _____mins.* | | ❑ Yes | ❑ No | ❑ N/A |
| 5. Child sleeps about the same amount each day | | ❑ Yes | ❑ No | ❑ N/A |
| 6. Child wakes up by him/herself<br>• *Child's usual wake time is ____:____ am* | | ❑ Yes | ❑ No | ❑ N/A |

**Directions:** Please complete Section 2 using the following rating scale:

0 = Not Sleepy    1 = Very Sleepy    2 = Falls Asleep

| **Section 2:** Child has appeared very sleepy or fallen asleep during the following… | Rating |
|---|---|
| 7. Watching TV | |
| 8. Riding in a car | |

**Directions:** Please complete Section 3 using the following rating scale:

1 = Rarely (0-1)    2 = Sometimes (2-4)    3 = Usually (5-7)

| Section 3 | Rating | Problem? | | |
|---|---|---|---|---|
| 9. Child falls asleep in parent's or sibling's bed | | ❑ Yes | ❑ No | ❑ N/A |
| 10. Child struggles at bedtime (cries, refuses to stay in bed, etc.) | | ❑ Yes | ❑ No | ❑ N/A |
| 11. Child needs parent in the room to fall asleep | | ❑ Yes | ❑ No | ❑ N/A |
| 12. Child is afraid of sleeping alone | | ❑ Yes | ❑ No | ❑ N/A |

| | | | | |
|---|---|---|---|---|
| 13. Child sleeps too little | | ❑ Yes | ❑ No | ❑ N/A |
| 14. Child is afraid of sleeping in the dark | | ❑ Yes | ❑ No | ❑ N/A |
| 15. Child has trouble sleeping away from home (visiting relatives, vacation) | | ❑ Yes | ❑ No | ❑ N/A |
| 16. Child moves to someone else's bed during the night (parent, sibling, etc.) | | ❑ Yes | ❑ No | ❑ N/A |
| 17. Child awakens once during the night | | ❑ Yes | ❑ No | ❑ N/A |
| 18. Child awakens more than once during the night<br>• *A night waking usually lasts _____ mins.* | | ❑ Yes | ❑ No | ❑ N/A |
| 19. Child talks during sleep | | ❑ Yes | ❑ No | ❑ N/A |
| 20. Child is restless and moves a lot during sleep | | ❑ Yes | ❑ No | ❑ N/A |
| 21. Child sleepwalks during the night | | ❑ Yes | ❑ No | ❑ N/A |
| 22. Child wets the bed at night | | ❑ Yes | ❑ No | ❑ N/A |
| 23. Child grinds teeth during sleep (your dentist may have told you this) | | ❑ Yes | ❑ No | ❑ N/A |
| 24. Child awakens alarmed by a frightening dream | | ❑ Yes | ❑ No | ❑ N/A |
| 25. Child awakens during night screaming, sweating, and inconsolable | | ❑ Yes | ❑ No | ❑ N/A |
| 26. Child snores loudly | | ❑ Yes | ❑ No | ❑ N/A |
| 27. Child seems to stop breathing during sleep | | ❑ Yes | ❑ No | ❑ N/A |
| 28. Child snorts and/or gasps during sleep | | ❑ Yes | ❑ No | ❑ N/A |
| 29. Child wakes up in a negative mood | | ❑ Yes | ❑ No | ❑ N/A |
| 30. Adults or siblings wake up child | | ❑ Yes | ❑ No | ❑ N/A |
| 31. Child has difficulty getting out of bed in the morning | | ❑ Yes | ❑ No | ❑ N/A |
| 32. Child takes a long time to become alert in the morning | | ❑ Yes | ❑ No | ❑ N/A |
| 33. Child seems tired in the morning | | ❑ Yes | ❑ No | ❑ N/A |

## OFFICE USE ONLY

| | |
|---|---|
| Total Score | |

# Adolescent Sleep Hygiene Scale (teens 13+)

Patient Name: _____ Date of Birth: _____/ _____/ _____

**Please have the teen patient complete this form.**

**Directions:** Using the choices below, rate how often the following things have happened during the **past month**.

Answer "always" if it happened **100% of the time.**
Answer "frequently, if not always" if it happened **80% of the time.**
Answer "quite often" if it happened **60% of the time.**
Answer "sometimes" if it happened **40% of the time.**
Answer "once in a while" if it happened **20% of the time.**
Answer "never" if it has **not happened.**

**Rating Scale:**
1 = Always (100%)
2 = Frequently, if not always (80%)
3 = Quite often (60%)
4 = Sometimes (40%)
5 = Once in a while (20%)
6 = Never (0%)

| You & Sleep | Rating |
|---|---|
| 1. **During the day**… I take a nap that lasts more than 1 hour. | |
| 2. … I play or exercise for more than 20 minutes. | |
| 3. **After 6:00 in the evening**… I have drinks with caffeine (for example: cola, root beer, iced tea, coffee). | |
| 4. … I take a nap. | |
| 5. … I do some kind of physical activity (for example: exercise, play sports). | |
| 6. … I smoke or chew tobacco. | |
| 7. … I drink beer (or some other drinks with alcohol). | |
| 8. **During the 1 hour before bedtime**… I do things that make me feel calm or relaxed (for example: taking a hot bath/shower, listening to soft music, reading). | |
| 9. … things happen that make me feel strong emotions (sadness, anger, excitement). | |
| 10. … I am very active (for example: playing outside, running, wrestling). | |
| 11. … I do things that make me feel very awake (for example: playing video games, watching TV, talking on the telephone). | |
| 12. … I drink more than 4 glasses of water (or some other liquid). | |
| 13. **I go to bed**… and do things in my bed that keep me awake (for example: watching TV, reading). | |
| 14. … and think about things I need to do. | |
| 15. … feeling upset. | |
| 16. … and replay the day's events over and over in my mind. | |
| 17. … and worry about things happening at home or at school. | |
| 18. … with a stomachache. | |
| 19. … feeling hungry. | |

| | |
|---|---|
| 20. **I fall asleep**... while listening to loud music. | |
| 21. ... while watching TV. | |
| 22. ... in a brightly lit room (for example: the overhead light is on). | |
| 23. ... in one place and then move to another place during the night. | |
| 24. ... in a room that feels too hot or too cold. | |
| 25. **I sleep**... in a home where someone smokes cigarettes, cigars, or a pipe. | |
| 26. **I**... get too little sleep. | |

**For question #27 ONLY, please rate as follows:**
1 = Never     2 = Once in a while     3 = Sometimes     4 = Quite often     5 = Frequently, if not always     6 = Always

| | |
|---|---|
| 27. ... use a bedtime routine (for example: bathing, brushing teeth, reading). | |
| 28. ... use my bed for things other than sleep (for example: talking on the telephone, watching TV, playing video games, doing homework). | |
| 29. ... check my clock several times during the night. | |
| 30. **During the school week, I**... stay up more than 1 hour past my usual bedtime. *My usual school night bedtime is ____:____ ☐ am ☐ pm* | |
| 31. ... sleep in more than 1 hour past my usual wake time. *My usual school day wake time is ____:____ ☐ am ☐ pm* | |
| 32. **On weekends, I**... stay up more than 1 hour past my usual bedtime. *My usual weekend bedtime is ____:____ ☐ am ☐ pm* | |
| 33. ... sleep in more than 1 hour past my usual wake time. *My usual weekend wake time is ____:____ ☐ am ☐ pm* | |

# Vanderbilt Screen for Attention Deficit Hyperactivity Disorder (ADHD)*

**\*If you're concerned that your child might have ADHD, please complete this questionnaire for assessment.**

Patient Name: _____ Date of Birth: _____/ _____/ _____

Name of person completing form: _____ Relationship to patient: ❑ Parent ❑ Guardian ❑ Other: _____

---

**Directions:** Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the **past 6 months.**

Is this evaluation based on a time when the child was…? 
❑ On medication 
❑ Not on medication 
❑ Unsure

**Rating Scale:**

0 = Never

1 = Occasionally

2 = Often

3 = Very Often

| Symptoms | Rating |
|---|---|
| 1. Does not pay attention to details or makes careless mistakes with, for example, homework | |
| 2. Has difficulty keeping attention to what needs to be done | |
| 3. Does not seem to listen when spoken to directly | |
| 4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand) | |
| 5. Has difficulty organizing tasks and activities | |
| 6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort | |
| 7. Loses things necessary for tasks or activities (e.g., toys, assignments, pencils, books) | |
| 8. Is easily distracted by noises or other stimuli | |
| 9. Is forgetful in daily activities | |
| 10. Fidgets with hands or feet or squirms in seat | |
| 11. Leaves seat when remaining seated is expected | |
| 12. Runs about or climbs too much when remaining seated is expected | |
| 13. Has difficulty playing or beginning quiet play activities | |
| 14. Is "on the go" or often acts as if "driven by a motor" | |
| 15. Talks too much | |
| 16. Blurts out answers before questions have been completed | |
| 17. Has difficulty waiting his/her turn | |
| 18. Interrupts or intrudes in on others' conversations and/or activities | |
| 19. Argues with adults | |
| 20. Loses temper | |

| | |
|---|---|
| 21. Actively defies or refuses to go along with adults' requests or rules | |
| 22. Deliberately annoys people | |
| 23. Blames others for his/her mistakes or misbehaviors | |
| 24. Is touchy or easily annoyed by others | |
| 25. Is angry or resentful | |
| 26. Is spiteful and wants to get even | |
| 27. Bullies, threatens, or intimidates others | |
| 28. Starts physical fights | |
| 29. Lies to get out of trouble or to avoid obligations (i.e., "cons" others) | |
| 30. Is truant from school (skips school) without permission | |
| 31. Is physically cruel to people | |
| 32. Has stolen things that have value | |
| 33. Deliberately destroys others' property | |
| 34. Has used a weapon that can cause serious harm (e.g., bat, knife, brick, gun) | |
| 35. Is physically cruel to animals | |
| 36. Has deliberately set fires to cause damage | |
| 37. Has broken into someone else's home, business, or car | |
| 38. Has stayed out at night without permission | |
| 39. Has run away from home overnight | |
| 40. Has forced someone into sexual activity | |
| 41. Is fearful, anxious, or worried | |
| 42. Is afraid to try new things for fear of making mistakes | |
| 43. Feels worthless or inferior | |
| 44. Blames self for problems; feels guilty | |
| 45. Feels lonely, unwanted, or unloved; complains that no one loves him/her | |
| 46. Is sad, unhappy, or depressed | |
| 47. Is self-conscious or easily embarrassed | |

**Directions:** Please complete the Performance section using the following rating scale:

| 1 = Excellent | 2 = Above Average | 3 = Average | 4 = Somewhat of a problem | 5 = Problematic |
|---|---|---|---|---|

| Performance | Rating |
|---|---|
| 48. Overall school performance | |
| 49. Reading | |
| 50. Writing | |
| 51. Mathematics | |

| | |
|---|---|
| 52. Relationship with parents | |
| 53. Relationship with siblings | |
| 54. Relationship with peers | |
| 55. Participation in organization activities (e.g., teams) | |

**Comments:**