

BEHAVIOR MANAGEMENT SYSTEMS, INC

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Confidential Patient Information - Child and Adolescent

Patient Name: _____ Date of Birth: _____

Name of School and Current Grade Placement: _____

The following are some possible areas of concern that you may have for your child or adolescent at this time. Please check any areas about which you are currently concerned:

- | | |
|---------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> Irritable mood | <input type="checkbox"/> Impulsive behavior |
| <input type="checkbox"/> Crying/Sad mood | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Aggression toward others | <input type="checkbox"/> Danger to self |
| <input type="checkbox"/> Worries/Fears | <input type="checkbox"/> Headaches/Stomachaches |
| <input type="checkbox"/> Defiant behavior | <input type="checkbox"/> Temper Tantrums |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Complains that he/she is not liked by others |
| <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Poor concentration/attention |
| <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Drug Use |
| <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> Appetite Disturbances/Eating Problems |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Poor Self Esteem |
| <input type="checkbox"/> Other concerns: _____ | |

Has this child ever been treated for behavioral, psychological, or emotional problems? **Yes No**

If yes, please explain: _____

Current medications and dose (please include vitamins and over-the-counter medications):

Has this child been the victim of or witnessed any emotional/physical/sexual abuse or been exposed to any other traumas? **Yes No**

If yes, please explain: _____

Family History:

Names of Family Members Living in the Home: _____

Do both biological parents live in the home? **Yes No** (if no, please explain.) _____

Has anyone in the immediate family been treated for behavioral, psychological, emotional problems or problems with alcohol or substance abuse? **Yes No**

Is there any family history of problems with learning or other school problems? **Yes No**

If you answered "yes" to either of the above questions, please explain: _____

Developmental, Medical and School History:

Were there any complications during pregnancy, birth or delivery? **Yes No**

Were there any delays in development (sitting, walking, talking, or toilet training)? **Yes No**

Are there problems with learning? **Yes No**

If yes, does this child receive Section 504 or IDEA special education services? **Yes No**

Has the child had any surgeries or injuries requiring medical attention? **Yes No**

Is this child/adolescent currently being treated for a medical condition? **Yes No**

If you answered "yes" to any of the above, please explain: _____

What do you consider to be your child's current strengths: _____

Thank you for taking the time to complete this form. It will allow us to be more efficient in helping you and your child.