

Parents, please complete to the
best of your ability.

MEDICAL HISTORY FORM

SILVER LAKE PEDIATRICS
33017 PROFESSIONAL DRIVE
LEESBURG FL 34788
352-314-2275

Person completing this form: _____ Date _____

Relationship to child: _____ Child's primary language: _____

Child's Name: _____ Sex: _____ Date of Birth: _____

Mailing Address _____

City _____ County _____ State _____ Zip _____

Home Phone () _____

Child's Primary Care Physician (PCP) Name: _____

Mailing Address _____

City _____ County _____ State _____ Zip _____

Office Phone () _____ Who referred you to this clinic _____

Specific Concerns

What specifically concerns you about your child? Describe your concerns and what you hope to gain from the evaluation?

When were you first aware of this problem?

Composition of Family in which child currently resides:

Mother's Name _____ Age _____

Relationship: Biological ☐ Adoptive ☐ Step ☐ Foster ☐ Other ☐ _____

Education: _____

Occupation: _____

Address of Employment: _____

Home Phone () _____ Work Phone: () _____

Can you be contacted at work? Yes ☐ No ☐ Approximate annual gross income? _____

Father's Name _____ Age _____

Relationship: Biological ☐ Adoptive ☐ Step ☐ Foster ☐ Other ☐ _____

Education: _____

Occupation: _____

Address of Employment: _____

Home Phone () _____ Work Phone: () _____

Can you be contacted at work? Yes ☐ No ☐ Approximate annual gross income? _____

Who is the child's legal guardian? _____

Persons residing in the home with child:

Name	Age	Sex	Relationship

If parent works, who cares for child? _____

Events In Family:

Have any of the following events occurred in the child's immediate family in the past year?

Family moved?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Death, divorce, separation, loss of family member?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Marriage, reconciliation, pregnancy, a new family member?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Serious injury or illness, problems with aging relatives?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Loss of work, change jobs, retirement?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Frequent serious arguments or fights?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Money problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sex problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Drug or drinking problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Involvement with social services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Out of home placement of the child?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Serious trouble with the law?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mental illness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Some other serious problem?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(If yes, what? _____)		

Agency involved: _____ Caseworker: _____

Explanation of items marked "yes": _____

No.	Birth Weight	Current Age	Current Grade	Health or Developmental Problems/Comments

Concerning the child being evaluated:

Did you receive prenatal care? Yes ☐ No ☐

During which month did you start prenatal care? _____

Did you smoke cigarettes during your pregnancy? Yes ☐ No ☐ If yes, how many per day? _____

Did you drink alcohol during your pregnancy? Yes ☐ No ☐ If yes, number of drinks per week? _____

Did you use any narcotic or prescription drugs during or before your pregnancy? Yes ☐ No ☐

If yes, which ones? _____ How often? _____

Did any of the following occur during pregnancy? (Check those which DID occur)

- | | | |
|---|---|---|
| <input type="checkbox"/> decreased fetal movement | <input type="checkbox"/> morning sickness | <input type="checkbox"/> swelling |
| <input type="checkbox"/> high fever | <input type="checkbox"/> amniocentesis | <input type="checkbox"/> stressful events |
| <input type="checkbox"/> x-rays | <input type="checkbox"/> hospitalization | <input type="checkbox"/> significant trauma |
| <input type="checkbox"/> ultrasound | <input type="checkbox"/> operations | <input type="checkbox"/> special diet |
| <input type="checkbox"/> stress test | <input type="checkbox"/> accidents | <input type="checkbox"/> vaginal bleeding |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> toxemia | <input type="checkbox"/> unusual worries |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> premature labor | <input type="checkbox"/> any other problem(s) |

Please explain the items you checked: _____

Child's Birth

At birth of child - Mother's age: _____ Father's age: _____

Place of child's birth: Hospital name: _____

Address: _____

Physician's Name: _____

Was the baby born on time? _____ Late? _____ Early? _____ How many weeks? _____

Any problems with labor or delivery? Yes ☐ No ☐ Explain: _____

Type of anesthesia/pain relief/sedation: _____

Delivery was by: vaginal/natural _____ C-section _____ planned _____ emergency _____ breech _____ forceps _____

How many days in hospital? _____

Infant's condition at birth and in nursery: _____

Birth weight: _____ Birth length: _____ Head Circumference: _____

APGAR scores: _____

Please explain anything additional or exceptional about the birth or newborn period of your child: _____

Developmental History

Developmental Milestones: State the age when your child first did each of the following. Say "No" if your child has not yet done it. If you do not remember, leave it blank.

Smiled _____

Buttoned clothes _____

Held head erect _____

Dressed self _____

Rolled over _____

Imitated sound _____

Sat alone _____

Said "mama", "dada" _____

Crawled _____

Said other single words _____

Walked alone _____

Said 2-3 word phrases _____

Rode tricycle _____

Followed simple directions _____

Rode bicycle _____

Knew colors _____

Ate unaided with spoon _____

Started counting _____

Separated easily from mother _____

Recited total alphabet _____

Did you feel your child developed quickly? _____

or slowly? _____

Temperament

Please rate the following behaviors as your child appeared during infancy and toddlerhood:

Activity level - How active was your child? _____ How distractible? _____

Adaptability - How well did your child deal with transition and change? _____

Approach/Withdrawal - How well did your child respond to new places, people, and things? _____

Intensity - Was your child happy or unhappy? _____ Do adults notice how your child is feeling? _____

Mood - What was your child's basic mood? (Check one) Happy? ☐ Sad? ☐ Angry? ☐ Quiet? ☐

Regularity - Was your child predictable in patterns of sleep, appetite, etc...?

Child's Medical History

We need as complete a medical history of your child as possible. Please complete this part. Explain any items checked "YES" in the explanation space and include as much information as possible about the item. Use more paper if necessary.

Has child ever been treated for or had a history of:

No.	Item Description	No	Yes	Explanation
1	Abdominal pain/bowel problems			
2	Allergies, including foods or drugs			
3	Anemia			
4	Birth Defects			
5	Concussion/significant head injury			
6	Dental problems			
7	Drooling			
8	Ear Infections			
9	Eating problems			
10	Headaches			
11	Hearing loss			
12	Heart condition			
13	Hemorrhaging or blood disorders			
14	Hormone problems			
15	Ingesting toxins/poisons			
16	Joint or bone problems			
17	Muscular problems			
18	Seizures or convulsions			
19	Significant accidents			
20	Skin diseases			
21	Tics (eye blinking, any non-purposeful repetitive movement)			
22	Urinary problems or infections			
23	Lung or breathing problems			
24	Visual/eye problems			
25	Other			

Hospitalizations: List any hospitalizations, operations or accidents of child. _____

Medications: List medication child currently takes: _____

Current Weight _____ Current Height _____

Has child been immunized? Yes ☐ No ☐ Up to date? _____

Educational History

List pre-schools and schools this child has attended:

School:

Dates:

Has this child ever repeated one or more grades? If so, which grade(s)? _____

Has this child ever been in special education, or received resource room help or tutoring?

When

Where

What kind?

Describe any current school problems: _____

Has this child ever received any developmental evaluations or testing in the past?

What type?

Where

What kind?

Briefly describe this child's attitude toward school:

Other Information: Please list other items that you may feel are relevant to your child behavior?

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

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 ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

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Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance Academic Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments: _____

Please return this form to: _____

Mailing address: _____

Fax number: _____

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____

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Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this Form: _____ Date: _____

Name of Child: _____

		Please mark under the heading that best fits your child			For Office Use		
		NEVER	SOME-TIMES	OFTEN	I	A	E
1.	Fidgety, unable to sit still						
2.	Feels sad, unhappy						
3.	Daydreams too much						
4.	Refuses to share						
5.	Does not understand other people's feelings						
6.	Feels hopeless						
7.	Has trouble concentrating						
8.	Fights with other children						
9.	Is down on him or herself						
10.	Blames others for his or her troubles						
11.	Seems to be having less fun						
12.	Does not listen to rules						
13.	Acts as if driven by a motor						
14.	Teases others						
15.	Worries a lot						
16.	Takes things that do not belong to him or her						
17.	Distracted easily						
(scoring totals)							

Scoring:

- Fill in unshaded box on right with: "Never" = 0, "Sometimes" = 1, "Often" = 2
- Sum the columns.
PSC17 Internalizing score is sum of column I
PSC17 Attention score is sum of column A
PSC17 Externalizing score is sum of column E
PSC-17 Total Score is sum of I, A, and E columns

Suggested Screen Cutoff:

PSC-17 - I ≥ 5
PSC-17 - A ≥ 7
PSC-17 - E ≥ 7
Total Score ≥ 15

Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.

PSC-17 may be freely reproduced.

Created by W Gardner and K Kelleher (1999), and based on PSC by M Jellinek et al. (1988)
Formatted by R Hilt, inspired by Columbus Children's Research Institute formatting of PSC-17