PHOENIX CHILDREN'S Medical Group®

Division of Neuroscience

BEHAVIORAL HISTORY

Behavioral History			
	No Problem	Some Problem	Extreme Problem
ATTENTION ISSUES			
Inattention			
Distractibility			
Difficulty starting / completing task			
Does not listen			
Problems following instructions			
Problems with organization			
Loses things			
Forgetful			
ACTIVITY LEVEL			
Hyperactivity − always on the go			
Shifts from one uncompleted activity to another			
Impulsivity −interupts			
Difficulty playing quietly			
Fidgety			
Blurts out answers			
Problems waiting turn			
Gets up from seat			
Doesn't sit for mealtime			
Excessive running / climbing			
Talks execessively			
DISRUPTIVE BEHAVIORS			
Temper outbursts			
Low frustration tolerance			
Engages in dangerous behaviors			
Does not learn from experience			
Argues with adults			
Angry			
Aggression			
Destructuve			
Self−injurious			
Destructive / break things			
Lies			
Steals			
Set fires			
SOCIAL BEHAVIOR			
Prefers to play alone			
Poor eye contact			
Does not turn when name is called			
Does not pretend play			
Does not recognize anothers distress			
Initiates play with peers/others			
Unresponsive to the social advances of peers			
If verbal, quality of to and fro conversation			
Uses gestures to communicate needs			
Uses gestures with words to communicate			
Seeks to share pleasure with others			
Teases others			
Picked on by others			
Few or no friends			

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BEHAVIORAL HISTORY

RITUALISTIC / REPETITIVE BEHAVIORS			
Difficulties with change in routine			
Problems with transitions			
Perfectionistic			
Repetitive behaviors			
Difficulty with stopping in the middle of an activity			
Self−stimulatory behaviors			
SENSORY ISSUES			
Hypersensitivity to noises (toilet flushing, hair dryer, etc.)			
Tactile hypersensitivity (tags on clothes, wearing shoes, brushing teeth and hair)			
Problems with food textures (Texture preferences, choking, gagging)			
Sensory−seeking (climbing / pressure)			
Licks / smells things, people			
EMOTIONAL CONCERNS			
Sad or happy			
Cries a lot			
Mood changes without reason			

PAST PSYCHOLOGICAL/PSYCHIATRIC TREATMENT

Dates	Provider	Type of Evaluation	Response + / −

Has this child been in a psychiatric hospital?

When?_____ Where?_____ Diagnosis?_____

Form completed by: _____ Date:_____

Relationship to patient: _____

Reviewed by Signature & Printed Name: _____

Date: _____Time: _____