Advanced Health Solutions
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Pediatric
School Aged Children



Today's Date:

Child's Name:	Child's Date of Birth:
Mom's Name:	Mom's Phone Number:
Dad's Name:	Dad's Phone Number:
Mom's Occupation:	Dad's Occupation:
Address:	

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, books)	0	1	2	3	
8	Is easily distracted by noises or other stimuli	0	1	2	3	For Office Use Only
9	Is forgetful in daily activities	0	1	2	3	_____/9
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 others' conversations and/or activities	0	1	2	3	For Office Use Only _____/9

Symptoms (continued)		Never	Occasionally	Often	Very Often	
19	Argues with adults	0	1	2	3	
20	Loses temper	0	1	2	3	
21	Actively defies or refuses to go along with adult's 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	For Office Use Only
26	Is spiteful and wants to get even	0	1	2	3	_____/8
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 (i.e.. "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	
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	For Office Use Only
40	Has forced someone into sexual activity	0	1	2	3	_____/14
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	For Office Use Only
47	Is self-conscious or easily embarrassed	0	1	2	3	_____/7

Performance		Excellent	Above Average	Average	Somewhat of a Problem	Problematic	
48	Reading	1	2	3	4	5	
49	Writing	1	2	3	4	5	For Office Use Only 4s /3
50	Mathematics	1	2	3	4	5	For Office Use Only 5s /3

		Excellent	Above Average	Average	Somewhat of a Problem	Problematic	
51	Relationship with parents	1	2	3	4	5	
52	Relationship with siblings	1	2	3	4	5	For Office Use Only 4s _____ /4
53	Relationship with peers	1	2	3	4	5	
54	Participation in organized activities (e.g. Teams)	1	2	3	4	5	For Office Use Only 5s _____ /4

Other Conditions

Tic Behaviors: To the best of your knowledge, please indicate if this child displays the following behaviors:

1 **Motor Tics:** Rapid, repetitive movements such as eye blinking, twitching, head jerks, or rapid kicks.

☐ No tics present. ☐ Daily, but go unnoticed by most ☐ Daily, noticeable tics.

2 **Phonic (Vocal) Tics:** Repetitive noises including but not limited to throat clearing, coughing, whistling, sniffing, screeching, barking, or repetition of words or phrases.

☐ No tics present. ☐ Daily, but go unnoticed by most ☐ Daily noticeable tics.

3 If YES to 1 or 2, do these tics interfere with the child's activities (like reading, writing, walking, talking or eating)?

☐ No ☐ Yes

Previous Diagnosis and Treatment: To the best of your knowledge, please answer the following questions:

1	Has your child been diagnosed with a tic disorder or Tourette syndrome?	☐ No	☐ Yes
2	Is your child on medication for a tic disorder or Tourette syndrome?	☐ No	☐ Yes
3	Has your child been diagnosed with depression?	☐ No	☐ Yes
4	Is your child on medication for depression?	☐ No	☐ Yes
5	Has your child been diagnosed with anxiety disorder?	☐ No	☐ Yes
6	Is your child on medication for an anxiety disorder?	☐ No	☐ Yes
7	Has your child been diagnosed with a learning or language disorder?	☐ No	☐ Yes

Comments:

Chemical Stressors

Have you chosen to vaccinate your child? ☐ No ☐ Yes, on a delayed or selective schedule ☐ Yes, on schedule

Reason for vaccination: ☐ Informed decis ☐ Didn't know I had a choice ☐ It was recommended

Does your child receive annual flu shots? ☐ No ☐ Yes (informed decision) ☐ Yes, recommended by MD

Has your child been exposed to antibiotics? ☐ No Yes

If yes, how many doses in past 6 months? _____ Reason _____

Were probiotics used at the same time as antibiotics? ☐ No ☐ Yes

Has your child been exposed to medications, including OTC: ☐ No ☐ Yes

If yes, which ones? _____

If yes, how many doses in past 6 months? _____ Reason _____

Chemical Stressors (continued)

How many glasses of water/day does your child have?	☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+
How many glasses of juice and soda/day does your child have?	☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+
Does your child eat gluten?	☐ No ☐ Yes ☐ Trying to eliminate from diet
Does your child eat/drink dairy?	☐ No ☐ Yes ☐ Trying to eliminate from diet
Does your child eat refined sugars (white sugar), white bread and pasta?	☐ No ☐ Yes ☐ Trying to eliminate from diet
Does your child eat boxed/frozen foods?	☐ No ☐ Yes ☐ Trying to eliminate from diet
Do you choose organic foods?	☐ No ☐ Yes
If yes, which:	☐ Veggies ☐ Fruits ☐ Meats ☐ Grains ☐ All
Does your child eat any artificial sweeteners like Splenda, Aspartame, Amino Sweet, Diet Soda?	☐ No ☐ Yes
Does your child follow any other dietary restrictions?	☐ No ☐ Yes _____
Any food/drink allergies, sensitivities, intolerances?	☐ No ☐ Yes _____
Is your child exposed to second hand smoke?	☐ No ☐ Yes _____

Consent to Evaluation of a Minor Child

I _____ being the parent or legal guardian of _____,

(print name of consenting adult) (print name of minor)

hereby grant permission for my child to receive an evaluation including history, spinal scan, examination and x-rays if warranted. Any findings will be communicated before consenting to commencement of care, if appropriate.

_____ _____

Consenting Adult's Signature Date