COMPLETE CHILDREN'S HEALTH

Initial Behavior Questionnaire

Patient Name: _____

Primary Care Provider: _____

Preferred Pharmacy: _____

What are your concerns that brought you here today?

Current Medications:

_____ _____

_____ _____

_____ _____

Has your child had a previous evaluation by a Mental Health Professional? **Yes**___ **No** ____

If yes, Providers name: _____

School Attending: _____Grade: _____

Does your child get additional services through school or have an IEP or 504? **Yes**___ **No** ____

Explain:

Is your child receiving any therapy/counseling/OT/PT/Speech? **Yes**___ **No** ____

If yes, from who?

Any Family history of Mental Health Disorders? **Yes**___ **No** ____

If so, what?