



**CURRENT PROBLEMS:**

Please describe the reasons your child (you) was referred to the Behavioral

Pediatric/Medicine Program : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medical History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Psychiatric History: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your child (you) had any history of seeing a psychologist, psychiatrist, or counselor?

\_\_\_\_ Yes \_\_\_\_ No (Please list the names of doctors or therapist, dates, and length of treatment?) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your child (you) had any history of any hospitalizations (medical or psychiatric)?

\_\_\_\_ Yes \_\_\_\_ No (Please list dates, where and length of hospitalization?) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list the current medications and doses your child (you) is taking? (Prescribed or over the counter) \_\_\_\_\_

\_\_\_\_\_

Please list during the past year any nontraditional doctors or treatments your child (you) have used (e.g. Herbal medicine, chiropractic treatments, meditation, prayer, etc) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SLEEP:**

How long does it generally take your child (you) to fall asleep?

\_\_\_ <30 minutes?

\_\_\_ Between 30 minutes to one hour?

\_\_\_ Longer than an hour?

Does your child (you) watch TV or read in bed? \_\_\_ Yes \_\_\_ No

(Sleep hygiene)

Does your child (you) snore while sleeping? \_\_\_ Yes \_\_\_ No

Does your child (you) have breathing pauses or stop breathing while sleeping?

\_\_\_ Yes \_\_\_ No

Does your child (you) have a history of Obstructive sleep apnea? \_\_\_ Yes \_\_\_ No

Any family history of Obstructive sleep apnea? \_\_\_ Yes \_\_\_ No Who? \_\_\_\_\_

What time does your child (you) go to bed at night during the week? \_\_\_\_\_

What time does your child (you) fall asleep at night? \_\_\_\_\_

What time does your child (you) get up during the week? \_\_\_\_\_

How long does your child (you) sleep in on the weekend? \_\_\_\_\_

Is your child (you) sleepy during the day? \_\_\_ Yes \_\_\_ No

What time of the day would your child (you) be the sleepiest? \_\_\_\_\_

Does your child (you) take naps? \_\_\_ Yes \_\_\_ No If yes how often?

\_\_\_\_\_

Does your child (you) often fall asleep while eating or in other situations? \_\_\_ Yes \_\_\_ No

Does your child (you) sometimes lose your balance when you experience a strong emotion?

\_\_\_ Yes \_\_\_ No

Does your child (you) feel like your legs are paralyzed upon falling asleep or waking up?

\_\_\_ Yes \_\_\_ No

Does your child (you) have vivid dreams upon falling asleep? \_\_\_ Yes \_\_\_ No

Does your child (you) have a history of Nightmares? \_\_\_ Yes \_\_\_ No (late in the sleep period)

Does your child (you) have a history of Sleep Terrors? \_\_\_ Yes \_\_\_ No (early in the sleep period)

Does your child (you) have sore neck muscles? \_\_\_ Yes \_\_\_ No

What position does your child (you) sleep in? (on stomach, on side, on back)?

\_\_\_\_\_

How many pillows do you sleep on? \_\_\_\_\_

Where do you feel nervousness in your body? \_\_\_\_\_

\_\_\_\_\_

**ANY HISTORY OF:**

Diabetes? \_\_\_ Yes \_\_\_ No?

Asthma? \_\_\_ Yes \_\_\_ No?

Cancer? \_\_\_ Yes \_\_\_ No?

Head injuries? \_\_\_ Yes \_\_\_ No?

Academic problems? \_\_\_ Yes \_\_\_ No?

Attention problems? \_\_\_ Yes \_\_\_ No?

Hyperactivity? \_\_\_ Yes \_\_\_ No?

Learning problems? \_\_\_ Yes \_\_\_ No?

Headaches (or Other Pain Conditions)

When did your child (you) first start having headaches (or other pain conditions)?

\_\_\_\_\_ (Month and Year)

How long has your child (you) had headaches (or other pain conditions)?

\_\_\_\_\_ (Weeks; Months, Years)

How often does your child (you) get headaches (or other pain conditions)?

\_\_\_\_\_ (How many times a week/month?) (frequency)

How long do your child's (your) headaches (or other pain conditions) last?

\_\_\_\_\_ (Duration)

Rate the intensity of your child's (your) current headache (or other pain complaints) on a scale (0=no pain to 10=the worst pain) \_\_\_\_\_

Does your child's (your) headache (or other pain complaints) ever go to zero? (i.e. no pain) \_\_\_\_\_ Yes \_\_\_\_\_ No

What is the range of your child's (your) headache (or other pain complaints) (0 –10) from a low of \_\_\_\_\_ to a high of \_\_\_\_\_

Where does your child's (you) hurt? (front, back, one side, both sides, top of the head, behind the eyes or ears, non-localized) \_\_\_\_\_

When does your child (you) get headaches (or other pain complaints)? \_\_\_\_\_

Do headaches (or other pain complaints) awaken your child (you) from sleep? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does your child (you) get sick to your stomach and/or throw up when having headaches (or other pain complaints)? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is there a family history of headaches, migraines, or other pain complaints? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does your child (you) have runny nose? \_\_\_\_\_ Yes \_\_\_\_\_ No

Nasal congestion \_\_\_\_\_ Yes \_\_\_\_\_ No

Sneezing \_\_\_\_\_ Yes \_\_\_\_\_ No

For more than two hours a day? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does your child (you) get "sinus headaches?" \_\_\_\_\_ Yes \_\_\_\_\_ No

Does your child (you) have seasonal allergies? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does your child (you) have any history of dental, orthodontic, TMJ problems or wear braces/or a retainer? \_\_\_\_\_ Yes \_\_\_\_\_ No

When did your child (you) begin orthodontic treatments (date) \_\_\_\_\_

Did your child (you) develop headaches or other pain conditions before, during, or after any orthodontic treatments?  
\_\_\_\_\_

Does your child (you) have any dietary triggers for headaches?  
\_\_\_\_\_

How much caffeine does your child (you) consume? (e.g. coffee, tea, cokes, chocolate, etc..) \_\_\_\_\_ (day/week)

How often does your child (you) eat processed and/or fast foods? \_\_\_\_\_ (day/week)

How much water does your child (you) drink in a day \_\_\_\_\_ (glasses).

How much milk does your child (you) drink in a day \_\_\_\_\_ (glasses).

How is your child's (your) appetite? Good? \_\_\_\_\_ Poor \_\_\_\_\_

How is your child's (your) energy level? Good? \_\_\_\_\_ Poor \_\_\_\_\_

Any weight losses in the past year? \_\_\_\_\_Yes \_\_\_\_\_No; Any weight gains? \_\_\_\_\_Yes \_\_\_\_\_No

Has your child (you) currently been feeling sad or depressed? \_\_\_\_\_Yes \_\_\_\_\_No

Has your child (you) thought about hurting (killing) self or others? \_\_\_\_\_Yes \_\_\_\_\_No

If so, has your child (you) thought about how to do this? \_\_\_\_\_Yes \_\_\_\_\_No

Does your child (you) have a way/or a method to hurt self? \_\_\_\_\_Yes \_\_\_\_\_No

Have you ever thought of hurting yourself or others? \_\_\_\_\_Yes \_\_\_\_\_No

Is there a gun in the home? \_\_\_\_\_Yes \_\_\_\_\_No

(If yes is there a gun lock on it? \_\_\_\_\_Yes \_\_\_\_\_No

Has anyone ever hurt or abused your child (you) in the past? \_\_\_\_\_Yes \_\_\_\_\_No \_\_\_\_\_

---

---

Any major losses, changes in the home, or stressors in the past year (e.g. divorce, deaths, job changes, changes in health or financial status?) \_\_\_\_\_

---

---

Are there any current family conflicts? \_\_\_\_\_

---

Is there smoking in the family? (Who, for how long, and how often?) \_\_\_\_\_

---

Any history of substance abuse? \_\_\_\_\_

Is there marijuana use? \_\_\_\_\_Yes \_\_\_\_\_No

Cocaine? \_\_\_\_\_Yes \_\_\_\_\_No

List other drugs? \_\_\_\_\_

Is there alcohol use in the family? \_\_\_\_\_Yes \_\_\_\_\_No; (How much and how often?)

---

For the person in the family who uses alcohol: (CAGE)

Have you ever felt the need to cut down on your drinking? \_\_\_\_ Yes \_\_\_\_ No

Have you ever felt annoyed by someone criticizing your drinking? \_\_\_\_ Yes \_\_\_\_ No

Have you ever felt bad or guilty about your drinking? \_\_\_\_ Yes \_\_\_\_ No

Have you ever had a drink first thing in the morning to steady your nerves and get rid of a hangover? \_\_\_\_ Yes \_\_\_\_ No

What does your child (you) do for exercise and how often do you exercise per week/month? (e.g. working out, running-0 to 7/week) \_\_\_\_\_

What does your child (you) like to do for fun? \_\_\_\_\_

How often does your child (you) bath or shower? \_\_\_\_\_

How often does your child (you) wash your hands? \_\_\_\_\_

How often does your child (you) brush your teeth? \_\_\_\_\_

About how many times a year does your child (you) get symptoms of a cold or the flu? \_\_\_\_\_

Is your child (you) able to keep their bed dry at night? \_\_\_\_ Yes \_\_\_\_ No.

In an average week, how many times can your child (you) keep the bed dry? (0-7) \_\_\_\_

Does your child (you) have bowel movements (BM's) daily? \_\_\_\_ Yes \_\_\_\_ No?

Any history of constipation or stool soiling? \_\_\_\_ Yes \_\_\_\_ No?

Does your child (you) wear pull-ups at night? \_\_\_\_ Yes \_\_\_\_ No?

Does your child have daytime accidents? \_\_\_\_ Yes \_\_\_\_ No?

Has your child ever had a urinary tract infection? \_\_\_\_ Yes \_\_\_\_ No?

Have any sibling had the same problem? \_\_\_\_ Yes \_\_\_\_ No?

Did either parent ever have enuresis? \_\_\_\_ Yes \_\_\_\_ No?

Does your child have difficulty starting a urine stream? \_\_\_\_ Yes \_\_\_\_ No?

Has anyone punished your child for bedwetting? \_\_\_\_ Yes \_\_\_\_ No?

For women: Have you ever lost an infant in the last month of pregnancy or in the first month of life? \_\_\_\_ Yes \_\_\_\_ No;

Have you ever had a child with low birth rate or born too small? \_\_\_\_ Yes \_\_\_\_ No?

If you have experienced one of the above, what do you think the cause or the causes were?

---

Notes: \_\_\_\_\_

---

---

---

---

---

**AUTHORIZATION FOR RELEASE OF INFORMATION**

Your child (you) name below has been referred for evaluation and or treatment by:

\_\_\_\_\_ Jeffrey E. Lazarus, M.D. The parent's signature below constitutes permission for the consulting doctor to release to and receive from, institution and professionals named below, all facts known about past and present physical and psychological condition, including written reports and verbal information.

Permission is hereby given to:

Jeffrey E. Lazarus, M.D.  
467 Hamilton Avenue, Suite 4  
Palo Alto, California 94301

To receive from and release to:

Name: Dr. \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Hospital Number \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

Parent's Signature\* \_\_\_\_\_ Date \_\_\_\_\_ \*\*

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

\* If the patient is a minor, a parent or legal guardian must sign.

\*\* This authorization is valid for one year following the date of the signature.

Signature \_\_\_\_\_