| **Type of Health Problem (check all that apply)** | **yes** | **no** | **Age of child when occurred** |
|---|---|---|---|
| Trouble falling asleep | | | |
| Rocking/head banging | | | |
| Irritability | | | |
| Tics/Tremors | | | |
| Temper Tantrums | | | |
| Too little/too much sleep | | | |
| Self-destructive behavior | | | |
| Hospitalization | | | |
| Serious injury/accident | | | |
| Surgery | | | |
| Other serious condition | | | |

Does your child take medication at home?_____

If yes, please list medications and time of day it is taken:_____

_____

_____

_____

Additional comments or concerns:_____

_____

_____

_____