

Pediatric
History and Background Information
Past Medical History continued

Name: _____
 Date: _____
 D.O.B: _____

Maladaptive Behavior Ages 2 and up (only if ASD is indicated)

	Yes	No	Notes
Is your child Physically Aggressive			
Do they have tantrums			
Do they have impulse control			
Do they understand personal space			
Do they hit themselves or others			
Do they perseverate on a topic or item			
Do they acknowledge others in the room			
Do they prefer objects to people			
Do they avoid physical contact			
Do they reject change			
Do they have a difficult time transitioning between activities			

Do they demonstrate any of the following:

	Yes	No	Notes
Echolalia			
Hyperactivity			
Irrational Fears			
PICA			
Self-Talk			

What skills would you like to see improved through therapy _____

Signature: _____ Date: _____

