



Airway Pediatrics

Pre- Appointment Behavior Evaluation Questionnaire

Child's Name: _____

DOB: _____

Your Name: _____

Relationship to Patient: _____

Do you have concerns with your child's behavior? Please explain:

Has your child ever been diagnosed and given a treatment plan by another healthcare professional? If yes, by who and what was their diagnosis and treatment?

Current Medication and dosage:

Does the child's school or teachers have concerns with their behavior? If yes, please explain:

Do you have concerns with your child hurting themselves or others? If yes, please explain:
