

## Supplemental Health History Form

Patients Name: \_\_\_\_\_ File #: \_\_\_\_\_

Has your child ever been diagnosed with, or shown any signs of the following behavioral conditions:

- Autism – Level \_\_\_\_\_
- ADHD
- Tourette Syndrome
- Anxiety Disorder
- Depression
- Cerebral Palsy

If yes, date of diagnosis: \_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_