**PATIENT INFORMATION AND REGISTRATION**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Last First MI**

**Social Security #\_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_**

**Gender: [ ] Male [ ] Female Home Phone #: ( ) -**

**Mom’s Cell Phone #:( ) - Dad’s Cell Phone #: ( ) -**

**Mom’s Work Phone #: ( ) - Dad’s Work Phone #: ( ) -**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_**

**Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Siblings’ Names: 1.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ 2.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_**

 **3.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ 4.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_**

**Pharmacy:­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Party Responsible for Payment (If other than Patient)**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D. O. B.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drivers License #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Information**

**Primary Insurance Comp.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy Holder’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D. O. B.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy I. D. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I certify the information provided is correct and irrevocably authorize services be provided to the above named patient.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient/Parent or Guardian**

NOTICE TO PATIENTS

All balances are due and payable in full at the time of treatment, unless other arrangements are made prior to appointment. We are required to notify you that certain services that may be deemed necessary by your Physician may not be covered by your Private Insurance, Medicare or Medicaid. Your Physician will discuss this with you if it is applicable.

## FINANCIAL AGREEMENT AND CANCELLATION POLICY

Remember that payment is your responsibility, regardless of insurance or third party involvement.

**I certify that I will be responsible for payment for services rendered at the time of service. I understand that there will be a charge for telephone consults over 5 minutes plus the cost of any long distance charges. I also understand that if I do not show up or if I give less than 24 hours notice of cancellation, I am responsible for the charge for the visit.**

**I authorize the provider of service to receive payment from my Primary and Secondary Insurance on my behalf if the provider has an active contract with your insurance company.**

##### Patient Consent for the Disclosure of Information

**I have read the NOTICE OF PRIVACY PRACTICES and have had any questions answered by this office. I understand that by signing this form I consent to the following:**

a] *Sharing information for purposes of treatment:* You will share my information with all members of my treatment team, both within this office and with other providers [personal and institutional] in order to provide me with quality care and the educational/wellness programs specified in my insurance plan;

b] *Sharing of Information for Purposes of Payment:* You will share all necessary information with my insurer[s], payor[s], governmental entities [such as Medicare, Medicaid, etc.]and their representatives [including, but not limited to benefit determination and utilization review] as well as your representatives involved in the billing process [including, but not limited to] claims representatives, data warehouses, billing companies]

#### c] *Sharing Of Information For Purposes Of Operations:* You will share all information necessary for ongoing operations of this office, including [but not limited to] the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

# My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

Patient's Name [printed] Date

Patient's Signature [or guardian, if a minor]

**MEDICATION REFILL POLICY**

ALL MEDICATION REFILLS NEED TO BE REQUESTED **48 HOURS** IN ADVANCE.

PLEASE CONTACT YOUR PHARMACY DIRECTLY FOR ALL REFILL REQUESTS.

* Refills that need to be filled immediately or prior to the 48 hour notification may be assessed a fee up to **$40** per prescription.
* If a non-emergency refill is granted on a weekend, you will be charged a **$40** fee.

**TRIPLICATE PRESCRIPTIONS**

**(RITALIN, DEXEDRINE, AND ADDERALL)**

* **We will charge you a $25.00 fee per prescription to rewrite a lost or expired prescription.**
* **Please return expired or found prescriptions to our office.**

**RETURN CHECK POLICY**

* **There will be a $25.00 service charge for all returned checks. In the event two checks have been returned due to insufficient funds, we must ask that you pay for your sessions thereafter by cash or credit card.**
* **This office utilizes the services of the County Attorney’s Hot Check Program.**

**I have read and understand the above and agree to the terms.**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

 **Patient/Authorized Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

**Witness/Clinic Representative Date**

Dear Parent,

 In order to make the best use of time during the initial evaluation, I ask that you fill out the following questionnaire. It helps focus the evaluation on the important issues.

 The first section addresses behaviors and emotions, the second section addresses health concerns (medical history and family history) and the third section addresses questions regarding development.

 Thank you!

 Caroline C. Batenburg, M.D.

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

Informant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ![MCj04382530000[1]]() **Emotions and Behavior** ![MCj04382530000[1]]()

**I notice the following things in my son/daughter:**

**Inattention NO SOME YES**

1. Fails to pay attention to details or makes careless errors. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
2. Doesn’t stay on task. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
3. Doesn’t listen when spoken to directly. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
4. Doesn’t follow through on instructions. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
5. Has difficulty organizing tasks. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
6. Often avoids or dislikes repetitive activities. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
7. Often loses things necessary for tasks. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
8. Is often easily distracted by things around him/her. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
9. Is often forgetful in daily activities. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_

**TOTAL YES: \_\_\_\_\_**

**Impulsivity/ Hyperactivity NO SOME YES**

1. Often fidgets or squirms in seats.\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
2. Often leaves seat when remaining seated is required. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
3. Often runs about or climbs excessively in situations

in which it is inappropriate. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_

1. Has difficulty playing or engaging in leisure activities

quietly. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_

1. Is often “on the go” or acts as if “driven by a motor.” \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
2. Often talks excessively. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
3. Often blurts out answers to questions before the question

is completed. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_

1. Often has difficulty awaiting turn. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
2. Often interrupts or intrudes on others. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_

 **TOTAL YES:** \_\_\_\_\_

At what age did these symptoms start? : \_\_\_\_\_\_

Have they been regularly present since that time? : \_\_\_\_\_\_

**Oppositional Behavior** **NO SOME YES**

1. Often loses temper. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
2. Often argues with adults. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
3. Often actively defies adult requests or rules. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
4. Often deliberately annoys people. Peers refuse to play

because he/she does silly/mean things. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_

1. Often blames others for mistakes. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
2. Is often touch or easily annoyed. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
3. Is often angry/ resentful for long periods. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
4. Often does mean or spiteful things to others. \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_

 **TOTAL YES:** \_\_\_\_\_

**My son/ daughter… NO SOME YES**

1. Often bullies or threatens others. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
2. Often starts physical fights. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
3. Has used a weapon in a fight. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
4. Has been physically cruel to others. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
5. Has been physically cruel to animals. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
6. Has stolen while confronting a victim. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
7. Has forced another into sexual activity. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
8. Has set fires with intent to damage. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
9. Has deliberately destroyed property. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
10. Has broken into a house or building. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
11. Often tries to “con” others out of things. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
12. Has stolen things without confronting the victim

 (money from home/shoplifting) \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_

1. Stays out late without permission (beginning

 before age 13). \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_

1. Has run away from home at least twice. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
2. Is truant from school. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_

**TOTAL YES:** \_\_\_\_\_

**Substance Abuse NONE 1-3 TIMES MONTHLY WEEKLY**

1. Drinks alcohol. \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_
2. Gets intoxicated. \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_
3. Uses marijuana. \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_
4. Uses amphetamines (speed). \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_
5. Uses cocaine. \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_
6. Uses IV or other drugs. \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

**Depression**

Does your child ever get sad or depressed or irritable for no reason? What things make him/her

grouchy?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How often does your child feel sad or grouchy?**

 **[ ] Never [ ] 1-3 times a month [ ] Weekly [ ] Daily**

**How long does the sadness last?**

 **[ ] Minutes [ ] An hour [ ] Several hours [ ] All day, constant**

**Is your child sad or grouchy today?**

 **[ ] No [ ] Yes**

**If yes, how long has this episode of sadness/irritability lasted?**

 **[ ] Less than 2 weeks [ ] 2-4 weeks [ ] Months [ ] Longer than a year**

**In the past, has he/she ever been sad for a whole year at a time?**

 **[ ] No [ ] Yes**

 **If yes, when? \_\_\_\_\_\_\_**

**In the past, has he/ she ever been sad for two straight weeks at a time?**

 **[ ] No [ ] Yes**

 **If yes, when? \_\_\_\_\_\_\_\_**

**Has your child lost interest in things he/she used to think were a lot of fun (other**

**than outgrowing them)?**

 **[ ] No [ ] Yes**

**Has he/she lost the ability to get pleasure out of activities (parties, being with**

**Friends, etc.)?**

 **[ ] No [ ] Yes**

**If yes, for how long?**

 **[ ] Less than 2 weeks [ ] 2-4 weeks [ ] Months [ ] Longer than a year**

**Has your child experienced the following associated with ongoing**

**sadness/irritability?:**

**NO SOME YES**

1. Weight loss or loss of appetite. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
2. Trouble falling asleep. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
3. Trouble waking up in the middle of the night. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
4. Falling asleep during the day. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
5. Very slow to move around or do things when sad. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
6. Paces, jumpy, or increases in irritability or activity

when sad. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_

1. Loss of energy. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
2. Makes negative comments about self, blames self for

Things that are not his/her fault. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_

1. Sad thoughts keep him/her form concentrating. \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_

**Does your child talk about hurting him/herself or say he/she wishes he/she**

**were dead?**

 **[ ] No [ ] Yes**

**Has your child ever tried to hurt him/herself?**

 **[ ] No [ ] Yes**

**Mania**

**Has your child had any times when he/she was unusually happy or over-excited for no reason?**

**Has he/she been happy or excited that you worried that something was wrong with him/her?**

 **[ ] No [ ] Yes**

**If yes, how long has he/she been that way?**

 **[ ] Less than 2 weeks [ ] 2-4 weeks [ ] Months [ ] Longer than a year**

**Anxiety**

**Does your child worry about the following: NO SOME YES**

1. Upcoming tests or grades? \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_
2. Meeting new people? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
3. How he/she will do in upcoming games or sports teams? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
4. Bad things happening to family? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
5. Kidnappers or burglars? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
6. That other kids don’t like him/her? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
7. Scared of trying new things? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
8. Worries excessively about bad things (storms, wars)? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_

**If the above symptoms of anxiety are present, does the patient:**

 **NO SOME YES**

1. Feel restless and keyed up? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
2. Feel and look tired? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
3. Say he/she can’t concentrate because of worrying

about a problem? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_

1. Get irritable when worried? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
2. Get physically tense when worried? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
3. Worries keep him/her form sleeping? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_

**Separation Anxiety**

**Does your child: NO SOME YES**

1. Worry that you will be hurt or die if you are away

from him/her? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_

1. Worry that he/she will be hurt or die if you are away

from him/her? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_

1. Refuse to leave you to go to school? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
2. Refuse to go to sleep without you near? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
3. Physically cling to you in public? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
4. Have nightmares about parents dying? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
5. Get headaches/stomach aches when you leave

him/her? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_

1. Throw temper tantrums to keep you from leaving? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_
2. When he/she is away from you , does he/she

repeatedly call and beg you to come for him/her? \_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_

**Phobias**

**Are there things your child is very scared of, much more than other children his age?**

 **[ ] No [ ] Yes**

**If yes, what are they?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Odd Behaviors**

**Please describe odd or bizarre behaviors exhibited by your child.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**During pregnancy, did the mother have problems with:**

 **YES NO**

High Blood Pressure \_\_\_\_ \_\_\_\_

 Diabetes \_\_\_\_ \_\_\_\_

 Depression \_\_\_\_ \_\_\_\_

 Anemia \_\_\_\_ \_\_\_\_

 Smoking \_\_\_\_ \_\_\_\_

 Alcohol/Drug Abuse \_\_\_\_ \_\_\_\_

 Serious Illness \_\_\_\_ \_\_\_\_

 Other problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did the mother feel about this pregnancy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did the father feel about this pregnancy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How long did labor last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **YES NO**

Was labor spontaneous? \_\_\_\_ \_\_\_\_

Was the baby born head first? \_\_\_\_ \_\_\_\_

Was delivery by Caesarian? \_\_\_\_ \_\_\_\_

Was the baby in an incubator? \_\_\_\_ \_\_\_\_

Was the baby full term? \_\_\_\_ \_\_\_\_

 If no, how early? \_\_\_\_\_\_\_

**How much did the baby weigh at birth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How many days did the baby stay in the hospital after birth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How many days did the mother stay in the hospital after birth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**At what age did your child do the following things:**

Smile: \_\_\_\_\_\_

Sit without help: \_\_\_\_\_\_

Crawl: \_\_\_\_\_

Walk without support: \_\_\_\_\_\_

Say first words: \_\_\_\_\_\_

Potty trained: \_\_\_\_\_\_

Completely weaned: \_\_\_\_\_\_

Speak in sentences: \_\_\_\_\_

**List any significant fears or sleep problems:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Date of last physical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACUTE CHILDHOOD ILLNESSES:**

**(e.g. strep throat)**

 **LENGTH AND / OR**

**ILLNESS DATE COMPLICATIONS OF ILLNESS TREATMENT**

|  |  |  |  |
| --- | --- | --- | --- |
| **1.** |  |  |  |
| **2.** |  |  |  |
| **3.** |  |  |  |

**[ ] NONE**

**CHRONIC ILLNESSES:**

**(e.g. asthma, chronic ear infection)**

 **LENGTH OF ILLNESS**

 **ILLNESS DATE OR CONDITION TREATMENT**

|  |  |  |  |
| --- | --- | --- | --- |
| **1.** |  |  |  |
| **2.** |  |  |  |
| **3.** |  |  |  |

**[ ] NONE**

**SURGERIES:**

 **LENGTH OF TIME OUTPATIENT TREATMENT**

 **SURGERY DATE IN HOSPITAL AFTER SURGERY**

|  |  |  |  |
| --- | --- | --- | --- |
| **1.** |  |  |  |
| **2.** |  |  |  |

**[ ] NONE**

**HOSPITALIZATIONS:**

 **LENGTH OF TIME**

 **ILLNESSES DATE IN HOSPITAL**

|  |  |  |  |
| --- | --- | --- | --- |
| **1.** |  |  |  |
| **2.** |  |  |  |

**[ ] NONE**

 **DESCRIBE TREATMENT**

 **ACCIDENTS DATE UNCONSCIOUS (i.e. hospitalization)**

|  |  |  |  |
| --- | --- | --- | --- |
| **1.** |  |  |  |
| **2.** |  |  |  |
| **3.** |  |  |  |

**[ ] NONE**

**FAMILY HISTORY:**

**Are there people in your biological family with:**

 **ILLNESS YES NO WHO?**

|  |  |  |  |
| --- | --- | --- | --- |
| Alcoholism |  |  |  |
| Depression |  |  |  |
| Bipolar Disorder or Manic Depressive |  |  |  |
| Heart Disease |  |  |  |
| Sudden cardiac death |  |  |  |
| Epilepsy or seizures |  |  |  |
| Learning disabilities |  |  |  |
| Memory problems/dementia |  |  |  |
| Anxiety or nervousness |  |  |  |
| High blood pressure |  |  |  |
| Hyperactivity/attention problems |  |  |  |
| Schizophrenia  |  |  |  |
| Substance Abuse |  |  |  |
| Thyroid Disease |  |  |  |
| Long QT Syndrome |  |  |  |
| Arrythmias |  |  |  |