PEDIATRIC NEUROLOGY ASSOCIATES, P.C.

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Diplomate of The American Board of Psychiatry and Neurology with Special Qualification in Child Neurology
Diplomate of The American Board of Pediatrics

Patient's Name_____ Date of Appointment_____
Address_____ Date of Birth_____
City_____State_____Zip_____
Home Phone _____ E-mail Address _____@_____

Mother_____ Occupation_____ Ph _____
Cell Ph _____

Father_____ Occupation_____ Ph _____
Cell Ph _____

Purpose of Consultation (include main complaints, referral source, medications, goals)
Referred by _____

Birth History

Birth Weight_____ Duration of Pregnancy_____
Type of Birth (regular____ or C/section___) Length of Hospital Stay_____
Complications during pregnancy, delivery, or perinatal period

Please enter age of the following Developmental Milestones

Motor		Speech/Language	
Sat Alone	_____	First words (give age)	_____
Walked alone	_____	Pointed to body parts	_____
Age of hand preference	_____	Two-word combinations	_____
Rode tricycle	_____	Used sentences	_____
Handwriting problems (specify)		Drools past 2 years old?	Yes or No
Coordination problems (specify)		Articulation or speech problems (specify)	
Athletic ability		Describe your child's communication skills?	
Sports/Hobbies		Any problems with social skills/friends?	

Medical History and Review of Systems

Allergies

Frequent ear infections

Past medical problems

Hospitalizations

Trauma or Surgery

Medications

Any concerns regarding	Yes	No
·Rate of growth or growth percentile		
·Weight loss/Fatigue		
·Fatigue		
·Heart palpitations/chest pain		
·Change in appetite		
·Abdominal pain		
·Constipation/Diarrhea		
·Episodes of fainting/passing out		
·Sleep disturbance/Snoring		
·Respiratory problems or asthma		
·Vision or hearing problems		

If Yes to any of the above, please describe

Describe learning, behavioral, organizational, or attentional problems during

Preschool

Kindergarten

Elementary School

Middle School

High School

College/Graduate School

Current grade_____ How is it going?

Special educational interventions your child has received
(Include IEP data, speech, physical, and occupational therapies)

Behavioral Symptom Checklist
(Please complete when appropriate.)

Rate each symptom with the following scale, and *write comments to the side.*

0: not a problem 1: slight problem 2: moderate problem 3: significant problem

Requires one-to-one attention to get work done_____
Impulsive (trouble waiting for turn, blurts out answers) _____
Hyperactive (fidgety, trouble staying seated) _____

Disorganized_____
Homework not handed in_____
Inconsistent work and effort_____
Poor sense of time_____
Does not seem to think through problems_____
Easily overwhelmed_____
Over-reacts_____
Blows up easily_____
Blames others for problems_____
Trouble switching activities_____
Hyper-focused at times_____

Poor handwriting_____
Certain academic tasks seem difficult (specify)_____

Lies, swears, or steals (specify)_____
Seems deliberately annoying or spiteful_____
Anxious, edgy, stressed or painfully worried_____
Obsessive thoughts or fears; perseverative rituals_____
Depressed, sad, pervasively irritable, moody, self-critical_____
Extreme mood swings, rages, lability, and anger_____
Tics: repetitive movements or noises_____

Awkward social skills_____
Not understand humor _____
Poor eye contact_____
Very "concrete" or literal; trouble with the hidden messages_____
Seems "odd"; limited range of interests and interactions_____
Over or under-responsive to sensory stimuli_____
Coordination difficulties_____

Other Problems

Conners' Questionnaire

(Complete if Attention Deficit Disorder is Suspected)

Patient's Name: _____ Date of Evaluation: _____

		Not at All	Just a Little	Pretty Much	Very Much
1	Restless in the "squirmy" sense				
2	Makes inappropriate noises when he/she shouldn't				
3	Demands must be met immediately				
4	Acts "smart" (impudent or sassy)				
5	Temper outbursts and unpredictable behavior				
6	Overly sensitive to criticism				
7	Distractibility or attention span a problem				
8	Disturbs other children				
9	Daydreams				
10	Pouts and sulks				
11	Mood changes quickly and drastically				
12	Quarrelsome				
13	Submissive attitude toward authority				
14	Restless. Always "up and on the go"				
15	Excitable, impulsive				
16	Excessive demands for teacher's attention				
17	Appears to be unaccepted by group				
18	Appears to be easily led by other children				
19	No sense of fair play				
20	Appears to lack leadership				
21	Fails to finish things that he/she starts				
22	Childish and immature				
23	Denies mistakes or blames others				
24	Does not get along well with other children				
25	Uncooperative with classmates				
26	Easily frustrated in efforts				
27	Uncooperative with teacher				
28	Difficulty in learning				

Comments

Family History/Social History

Relationship	Age	Medical problems	Grade/Degree	Educational problems
Mother	____	_____	_____	_____
Father	____	_____	_____	_____
Sib	____	_____	_____	_____
Sib	____	_____	_____	_____
Sib	____	_____	_____	_____

Any family history of neurological, psychiatric, or significant medical problems (include depression, bipolar disorder, explosive anger, suicide attempt, attentional disorder, OCD, Learning Disability, headaches, migraines, tics, Tourette syndrome, seizures, etc.)

Any current sources of stress within the family (separation/divorce, abuse, illness, death, recent move, witness to violence, etc.)

Sources of support within the family (mentors, tutors, grandparents, pets, spiritual endeavors, others)

Anything else you would like us to know. Thank you

Send consultation report to (give names and addresses)

*Reviewed by Dr.*_____

*Date*_____

Patient Treatment Waiver

Patient Name_____

I, _____, have requested treatment for my child/myself from Pediatric Neurology Associates, PC. I realize that without valid referral forms my insurance carrier, _____, will not reimburse Pediatric Neurology Associates, PC for consultations, office visits, or procedures. If my referrals are not valid for any reason or if I do not have the required referral forms from my Primary Care physician, Dr. _____, I will be responsible for payments for this and any subsequent visits or consultations.

Therefore, I agree that if Pediatric Neurology Associates, PC treats my child/myself and I do not supply the required referral form or referral number within seven (7) days from the date of service, I will then be responsible for payment in full of any and all charges connected with unauthorized visits.

Or, if a referral is not valid for any reason (out of date, loss of coverage, etc.,), then I agree that I will be responsible for payment in full of any and all charges connected with any unauthorized visits or services.

Signed_____ Date_____

Witness_____

Notice of Privacy Practices

Patient's Name_____

I, _____, acknowledge that I have received the Notice of Privacy Practices for Pediatric Neurology Associates, PC.

Signature_____

Relationship to patient_____

Date_____

Pediatric Neurology
Boston Children's Health Physicians
Until every child is well℠

Division Of Pediatric Neurology
755 North Broadway
Medical Services Building – Suite 540
Sleepy Hollow, NY 10591

Patients Name: _____

Patients Date Of Birth: _____

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone Number: _____

E-Mail Address: _____