Developmental Pediatrics
Boston Children's Health Physicians
Until every child is well™

NEW PATIENT REGISTRATION & INTAKE PACKET

When your forms are complete, please send to:

Email: DevelopmentalPediatrics@bchphysicians.org,

Fax: 914-345-1752

Or by Mail: 400 Columbus Avenue, Suite 190E, Valhalla, NY 10595

IN ORDER FOR US TO SCHEDULE AN APPOINTMENT FOR YOU, WE NEED THE FOLLOWING:

- **FRONT & BACK COPY OF INSURANCE CARDS**
- **DOCTOR TO DOCTOR REFERRAL (letter from PCP stating child is being referred to see Developmental Pediatrics)**
- **ANY SEPARATION/DIVORCE PAPERWORK STATING CUSTODY OR MEDICAL DECISION MAKING MUST BE SENT TO US**
- **NEW PATIENT PACKET**

Currently we are placing all patients on a waiting list. Once an appointment becomes available, the office will give you a call to schedule an appointment.

Developmental Pediatrics
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Until every child is well™

Office Address: 19 Bradhurst Ave, Suite 2400N, Hawthorne, NY 10532
Mailing Address: 400 Columbus Avenue, Suite 190E, Valhalla NY 10595
914-304-5250 | fax 914-345-1752
developmentalpediatrics@bchphysicians.org | www.bchphysicians.org

Thank you for choosing **Boston Children's Health Physicians Division of Developmental Pediatrics** for your child's care. In order to help you to continue to be an active part of your child's Health Care Team, we want to take this opportunity to share with you some aspects of how our office operates.

Our phones are answered on workdays from 8:30 AM until 4:30 PM. If you reach our voicemail during office hours, that means that all the receptionists are on another call, but if you leave a message, your call will be returned.

If you need to speak to your doctor, please call during office hours. On nights, weekends, and holidays, our phone system does not record messages. Prescription refills cannot be recorded after hours or on holidays.

If your child is on medication:

- At a visit here, your doctor will discuss with you when your child needs to come back for a follow up visit; very often renewing your child's medicine can be affected by whether or not a requested follow up appointment has been kept, or if a requested follow up appointment has been scheduled; we feel it is not good medical practice to renew medications without seeing the child on a regular basis.
- If you need a refill, please follow the prompts on the phone system. Please call while you still have 5-7 days of medication, as we may not be able to respond to a same day refill request. Please allow 24-48 hours to process your request.
- Also, please keep in mind that NYS regulations may prohibit us from adding refills to certain medication prescriptions.

If your child is under 18 years of age, and is being brought to a visit by someone other than a parent, a written note from the parent authorizing whomever is accompanying your child must be brought to the visit.

In order to protect the confidentiality of your child's records, we cannot release records, or discuss your child with anyone but a parent unless we have a signed HIPAA release form on file. Patients who are 18 or older are considered adults, and need to authorize their parents to participate in their care or receive records.

We want to make sure that your child is seen on time for a scheduled appointment. Please ensure that you check in for your appointment at least 15 minutes before the scheduled time, whether your appointment is scheduled for an in-office visit or via telehealth.

Lastly, the following registration and intake forms **must** *be returned before the appointment is scheduled. Please return these forms by* **fax 914-345-1752** *or by* **email,** DevelopmentalPediatrics@bchphysicians.org. *If you have any additional documents to provide, please send them along with these forms.*

Thank you,
The Division of Developmental Pediatrics

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Today's Date: _____

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Gender: ☐ Male ☐ Female

_____ Home Phone: _____

Patients Email (12&Over): _____ Cell Phone: _____

Primary Care Physician: _____ Phone: _____

Parent / Guarantor #1: _____ D.O.B.: _____

Mailing Address: _____ Relationship: _____

_____ Preferred Phone: _____

Email Address: _____ Work Phone: _____

Parent / Guarantor #2: _____ D.O.B.: _____

Mailing Address: _____ Relationship: _____

_____ Preferred Phone: _____

Email Address: _____ Work Phone: _____

Emergency Contact Name: _____

Phone Number: _____ Relationship to Patient: _____

The federal government is asking all *physicians to collect race and ethnicity information to monitor the quality of medical care and to ensure that all patients, regardless of race and ethnicity, get the best care possible. We are committed to providing culturally-sensitive, whole-person medical care and collecting this information also gives us information that can help us serve your family better. If you choose to provide us with this information, we will keep your identity confidential.*

With this in mind, we ask that you complete the following. If you choose not to participate, please indicate it below.

Which category best describes the patient's race?

☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other

Which category best describes the patient's ethnicity?

☐ Hispanic/Latino ☐ Non-Hispanic/Latino

If Hispanic/Latino: ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

☐ I do not wish to provide this information

INSURANCE INFORMATION

Primary Insurance Name: _____ Effective Date: _____

Insurance Address: _____

Member ID #: _____ Group #: _____

Policyholder Name: _____ Policyholder DOB: _____ Gender: ☐ M ☐ F

Mental Health Benefits Insurance Name: _____ ***ID #:*** _____

Secondary Insurance Name: _____ Effective Date: _____

Insurance Address: _____

Member ID #: _____ Group #: _____

Policyholder Name: _____ Policyholder DOB: _____ Gender: ☐ M ☐ F

Employer: _____

Employer Address: _____

Mental Health Benefits Insurance Name: _____ ***ID #:*** _____

Release of Information and Assignment of Benefits

I hereby authorize BCHP to release information regarding treatment or services rendered to Medicare/other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare/ other insurance company benefits be made to either me or on my behalf to BCHP for any services rendered. I have been advised that if my insurance requires a co-pay, it is due at the time of my visit. Otherwise, a $15 surcharge will be added to my bill.

_____ _____
Signature of Patient or Authorized Representative Date

INSURANCE CARDS

Insurance cards must be presented at each visit. If you do not present the insurance card at the time of the visit, you will be responsible for the payment of services rendered by Boston Children's Health Physicians, LLP.

REFERRALS

Please be advised that a completed referral from your primary care provider in order for services to be billed to your insurance company for each service rendered. Please contact your primary care provider to obtain a referral.

If we do not receive the appropriate referral, you will be responsible for payment of services rendered by Boston Children's Health Physicians, LLP.

_____ _____
Name of Patient (please print) Date of Birth

_____ _____
Name of Parent/Guardian (please print) Relationship to Patient

_____ _____
Signature of Patient (if over 18) or Parent/Guardian Today's Date

PATIENT FINANCIAL POLICY, ASSIGNMENT OF BENEFITS, AND CONSENT FOR TREATMENT

Thank you for choosing Boston Children's Health Physicians (BCHP) as your health care provider. Please be assured that the health of our patients is of the utmost importance to us. We thank you for taking the time to review our policies. Your understanding of our Financial Policy is important to our professional relationship with you. Please feel free to ask any questions or share any special concerns that you may have.

Your insurance benefits are determined in the contract between you and the insurance company, and it is important that you understand and follow the requirements of your specific insurance policy.

Co-Payments/Coinsurance/Deductibles

Your specific insurance plan determines the amounts you may be required to pay. Our contract with your plan and applicable laws limit us from discounting or waiving copayments, deductibles, or coinsurance for visits and procedures. Copays are required at the time of every visit, and BCHP accepts cash, check or credit card as payment.

Some insurance plans may require copays for each additional service performed at your appointment. If this is required by your insurance, we will require the additional copayment at the time of service. If you have any questions regarding the additional copay requirement, we suggest you contact your insurance carrier to review your plan details.

For your convenience, BCHP utilizes a credit card processing system which allows us to keep your credit card on file securely. Please note that no staff members at BCHP have access to your credit card number at any time. We will charge your card for amounts due, as indicated by your insurance carrier, unless you advise us otherwise.

No Show / Late Cancel Policy

A $40 surcharge will be applied to your balance if you (or your dependent) do not arrive for an appointment as scheduled and do not cancel 24 hours prior to the scheduled visit.

Insurance

We will require a copy of your (or your dependent's) insurance card for our files. It is your responsibility to inform us of any change in your insurance coverage.

Participating Plans

BCHP participates in most insurance plans. In order to properly bill your insurance company, we require all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient / guarantor responsibility for the entire bill. It is the insurance company that makes the final determination of your eligibility and benefits. You are responsible for any co- insurance, deductibles or non-covered services not paid by your insurance.

Non-Participating Plans

If we are out of network for your insurance and your insurance will be paying you directly, we expect payment at the time of service unless other arrangements have been made prior to the visit.

Referrals and Authorizations

For the insurance carriers where BCHP is a participating provider, it is our policy to implement and follow the referral and prior authorization guidelines set by the carrier. We will make every effort to inform you of your insurance requirements. However, it is ultimately your responsibility to know and understand what is required by your specific policy.

Specific information regarding authorization requirements can be found in your policy benefits. However, if you have questions, please reach out to the member services number printed on the back of your insurance card. When a referral or prior authorization is required (*i.e.*, when you need to see a specialist), you must obtain one from your assigned Primary Care Physician (PCP) or from the member services department which can be reached by calling the number on the back of your insurance card. ***This must be done prior to your***

appointment. Many plans require authorization to see a primary care physician **other than** the primary care physician already on file with your plan.

If the authorization is not provided, you may be asked to reschedule your appointment until one is obtained or to call your carrier before you are seen. Failure to follow insurance guidelines may result in you being financially responsible for full charges for services scheduled or rendered.

Self-Pay
Payment is expected at the time of visit unless other arrangements have been made with the office manager prior to the visit.

Annual Visits
Before making annual physical appointments, it is your responsibility to check with your insurance company regarding whether the visit will be covered as a “well” visit. Not all plans cover annual physicals.

Non-Covered Services
We pride ourselves on providing exceptional, state-of-the-art medical care and an extensive range of services for our patients. We offer many health screenings that are recommended by the American Academy of Pediatrics and our providers. Some insurance companies choose not to pay for recognized service codes and apply these services to a patient’s deductible.

Any non-covered service is your responsibility. This can include, but is not limited to, hearing screens, vision screens, lab work, and developmental screening--even when the services are provided during a “well care” visit. If not covered, you will be responsible for those charges according to your health care insurance plan. Because plans differ within each health care insurance company, we do not advise regarding what your plan will or will not cover.

Off Hours / Weekends / Holidays
There will be an additional charge / code submitted to your insurance company for patients seen on Saturdays, Sundays, federal holidays, and after normal business hours on weekdays. We are required by law to report all the charges for services provided. Some insurance companies cover the charge in full, and others assign all or part to patient responsibility. If you have any questions about your specific plan’s coverage, please ask your insurance company. Because insurance companies may offer several different health plans, it is impossible for us to know in advance if there will be any patient responsibility.

High Deductible Plans
For high deductible insurance plans, we may require a deposit towards your policy deductible requirements. You will receive a statement for any outstanding balances owed for services provided.

Divorce / Separation
BCHP is not a party in divorce or separation decrees, or in child support arrangements. Parents and guardians are presumed to have equal rights regarding the child’s care unless BCHP is given a valid court order limiting or terminating the rights of one parent or guardian over the child’s medical care and medical information. BCHP reserves the right to terminate the patient-provider relationship in the event that a dispute arises between the parents or guardians over the child’s care that interferes with our ability to provide care for the child. We bill one guarantor at one address. We do not handle billing or insurance coverage disputes between parents. In situations of divorce or separation of parents or guardians, the individual bringing in the child for services will be held financially responsible for any unpaid charges on the account.

Financial Hardship
We realize families may experience financial difficulty from time-to-time and we want to always be here to care for your children. Please contact our office manager to discuss payment options.

ACKNOWLEDGEMENT OF PATIENT FINANCIAL RESPONSIBILITY ASSIGNMENT OF BENEFITS, AND CONSENT FOR TREATMENT

I acknowledge that I have read the above and am responsible for services rendered by Boston Children's Health Physicians, LLP. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance. I understand that co-pays are due at time of check-in. Adolescents who come alone should be prepared to settle their visits at the time of service.

I authorize BCHP to release information to Medicare/other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to BCHP for any services rendered.

I authorize my insurance company to pay and mail directly to BCHP all medical benefits for payment of services rendered. I also authorize BCHP to endorse any checks received on my behalf for payment of services provided. I hereby irrevocably assign to BCHP all benefits under any policy of insurance, indemnity agreement, or any collateral source as defined by statute for services provided. This assignment includes all rights to collect benefits directly from my insurance company and all rights to proceed against my insurance company in any action, including legal suit, if for any reason my insurance company fails to make payment of benefits due. This assignment also includes all rights to recover attorney's fees and costs for such action brought by the provider as my assignee.

I have voluntarily presented for medical care and consent to such medical care and treatment including any diagnostic procedures and tests that the physician(s), his or her associates, assistants and other healthcare providers determine to be necessary. During treatment, I understand and acknowledge that no warranty or guaranty has been or will be made as to the result or cure of treatment. I have the legal right to consent to medical treatment because I am the patient, or I am the parent/guardian of the patient.

Name of Patient (please print)	Date of Birth
Name of Parent/Guardian (please print)	Relationship to Patient
Signature of Patient (if over 18) or Parent/Guardian	Today's Date

NO-SHOW POLICY

In an effort to serve to serve our patients and to ensure that available appointment times are used appropriately, BCHP has implemented a **no-show policy** for all our patients effective October 5, 2009.

You will be billed $40 if your child misses an appointment and you have not contacted us to cancel at least 24 hours prior to the scheduled appointment time. If the appointment is on Monday, you must contact us by noon on the Friday before.

To cancel an appointment, please call the office at 914-304-5250. If are not able to speak with a member of the administrative staff, please leave a detailed message with the date and time of your call. You may not cancel an appointment via email or through the patient portal.

Thank you for your cooperation.

Name of Patient (please print)	Date of Birth
Name of Parent/Guardian (please print)	Relationship to Patient
Signature of Patient (if over 18) or Parent/Guardian	Today's Date

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of Boston Children's Health Physicians, LLP's (herein after referred to as "BCHP") Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about BCHP's privacy practices or my rights with regard to my personal health information, I may contact BCHP's Privacy Officer for further information as set forth in the Notice.

Name of Patient (please print)	Date of Birth
Signature	Today's Date
Name of Parent/Guardian (please print)	Relationship to Patient
Signature	Today's Date

USE OF VOICEMAIL, EMAIL, AND TEXT MESSAGING

Voicemail, email, and text message offer an easy and convenient way to communicate but is not the same as calling your physician's office. You can't tell when your message will be read or responded to, or even if your doctor is readily available or on vacation. Boston Children's Health Physicians, LLP ("BCHP") will communicate with our patients (or their parents or guardians) by voicemail, email, and/or text message ***only*** if we receive your agreement to the terms set forth in this Consent. Your consent to these terms will apply to all BCHP clinical providers as well as non-clinical personnel of BCHP who are involved in your care, scheduling, billing and other activities.

- Use of voicemail, email, and/or text message is never appropriate for urgent or emergency health problems! You must call your physician's office or go to a hospital Emergency Department.
- Voicemail, email, and/or text message is not to be used as a substitute for face-to-face medical consultation with your physician and is at your physician's sole discretion.
- Voicemail, email, and/or text message is appropriate for communicating regarding routine matters that don't require a lot of discussion, such as prescription refill requests, referral and appointment scheduling requests and billing/insurance questions. BCHP may utilize voicemail, email, and/or text message at its discretion to send you information about our practice and services, including appointment reminders, our patient programs and new services.
- Your use of voicemail, email, and/or text message is not confidential, and it may not be encrypted. It is like sending a postcard through the mail. Our staff (clinical and non-clinical) may read or listen to your voicemails, emails, and/or text messages in the course of their work duties. If you send emails or text messages through a work account, your employer may have the legal right to read your email or texts.
- Voicemail, email, and/or text message mail should never be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- Voicemail, email, and/or text message may become a part of the medical record when it contains clinical information, and we believe it is appropriate to include it in the medical record. In such case, the message may be retained in the patient health record.

Consent to Voicemail, Email, and Text Usage for Communications from BCHP
*New York offices

By signing below, I authorize BCHP and its business associates to contact me by voicemail, automated email, and SMS text message to remind me of upcoming appointments and provide general health communications/information, including, but not limited to balance reminders and account status. If at any time I provide a phone number, an email or text address at which I may be contacted, I consent to receiving appointment reminders and other health care communications/information at that voicemail, email, or text address. I understand that this request to receive voicemail, email, and text messages will apply to all future appointment reminders and general health communications/information.

I understand that message/data rates may apply to messages sent through BCHP and its business associates to my cellular phone.

I know that I am under no obligation to authorize BCHP and its business associates to send me email and text messages as part of this program and that I may opt-out of receiving these communications from BCHP and its business associates at any time. If I opt-out of text messages or email, BCHP will utilize the phone number I have provided to contact me, and I will make sure BCHP has the correct phone number at all times.

I understand that voicemail, email, and text messaging are not secure formats of communication. There is some risk that individually identifiable health information or other confidential information contained in such voicemail, email, and text may be misdirected, disclosed to, or intercepted by unauthorized third parties. Information included in voicemail, email, and text messages may include date/time of appointments, name of physician, physician phone number, or general health related communications/information. BCHP and its business associates will use their good faith efforts to use the minimum necessary amount of protected health information in any communication.

By signing below, I indicate that (1) I am a patient or parent/guardian of the minor child or person lacking capacity to consent to their treatment listed below; (2) I am the primary user for the mobile phone number and email listed below; (3) I understand that any and all voicemail messages sent will be delivered to the mobile number provided below unless I provide a different number; (4) I understand the risk explained above, and I consent to receive voicemail, emails, and text messages via automated technology from BCHP and its business associates to the phone number, email address, and text message address I have provided.

I understand that if I am the parent/guardian of a minor child of thirteen (13) years of age or above, the minor child may choose to opt into and remove the parent/guardian from these communications from BCHP and its business associates.

Name of Patient (please print)	Date of Birth
Name of Parent/Guardian (please print)	Relationship to Patient
Signature of Patient (if over 18) or Parent/Guardian	Today's Date
Email Address	Mobile Phone Number

Minor Patient **Consent to Voicemail, Email, and Text Usage for Communications from BCHP**
*New York offices

If you are a patient residing in New York of thirteen (13) years of age or older, you may choose to opt into and remove your parent/guardian from healthcare related communications/information, including, but not limited to balance reminders and account status via voicemail, email, and text messaging from BCHP and its business associates.

Please be advised that voicemail, email, and text messaging are not secure formats of communication. There is some risk that individually identifiable health information or other confidential information contained in such voicemail, email, and text may be misdirected, disclosed to, or intercepted by unauthorized third parties. Information included in voicemail, email, and text messages may include date/time of appointments, name of physician, physician phone number, or general health related communications/information. BCHP and its business associates will use their good faith efforts to use the minimum necessary amount of protected health information in any communication. Message/data rates may apply to messages sent through BCHP and its business associates to your cellular phone.

You are under no obligation to authorize BCHP and its business associates to send you email and text messages as part of this program and that you may opt-out of receiving these communications from BCHP and its business associates at any time. If you opt-out of text messages or email, BCHP will utilize the phone number you have provided to contact you, so please make sure BCHP has the correct phone number at all times.

By signing below, you authorize BCHP and its business associates to contact you or your parent/guardian by voicemail, automated email, and SMS text message to remind you of upcoming appointments and provide general health communications/information. If at any time you provide a phone number, an email or text address at which you may be contacted, you consent to receiving appointment reminders and other health care communications/information at that voicemail, email, or text address. This request to receive voicemail, email, and text messages will apply to all future appointment reminders and general health communications/information.

Please note that if your insurance is billed for the subject treatment, communications regarding your treatment at BCHP may be sent by the insurance company to the listed address of the parent or guardian policy holder. Please also note that charges on a credit card are displayed on the card holder's monthly statement.

By signing below, you indicate that (1) You are a patient residing in New York of thirteen (13) years of age or older; (2) You or your parent/guardian is the primary user for the mobile phone number and email listed below; (3) You understand that any and all voicemail messages sent will be delivered to the mobile number provided below unless you provide a different number; (4) You understand the risk explained above, and consent to receive voicemail, emails, and text messages via automated technology from BCHP and its business associates to the phone number, email address, and text message address you have provided.

Name of Patient (please print)	Date of Birth
Signature of Patient	Today's Date
Email Address	Mobile Phone Number
Name of Parent/Guardian (please print)	Relationship to Patient

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Dear Parent/Guardian:

Please answer the following questions as best as you can, and send it via email or fax prior to your visit. If you have any questions about a specific item of information being asked, you can call before your appointment as the information will be covered during the visit.

Thank You.

Name of Child: _____ **Date of Birth:** _____

What concerns do you have about your child?

☐ **development** ☐ **learning** ☐ **speech/language** ☐ **attention** ☐ **behavior**

Please describe your concerns briefly:

_____

_____

_____

_____

Current or prior diagnoses (if any):

_____

_____

MEDICATIONS

Current medications: _____

Prior medications: _____

ALLERGIES

Does your child have known allergies to food or medication? ☐ Yes ☐ No

If yes, please list: _____

BIRTH HISTORY

Child's weight at birth: _____ lbs. _____ oz. How many weeks of gestation? _____ weeks

What type of delivery did you have?

☐ Vaginal delivery: ☐ normal/spontaneous ☐ Pitocin-induced

☐ Cesarean Section: If so, was this due to ☐ repeat ☐ fetal distress

How old was the mother at the time of delivery? _____ years

What number pregnancy was this? _____ What number delivery was this? _____

Were there any maternal medical problems during the pregnancy? ☐ Yes ☐ No

If yes, what was/ were the problem(s)? _____

_____

Were there any medications taken during the pregnancy? ☐ Yes ☐ No

If yes, what medication(s) and why? _____

_____

Was your child in the NICU? ☐ Yes ☐ No

If yes, for how long and why? _____

DEVELOPMENTAL HISTORY

Please list age at which your child:

Sat up	_____	Walked alone	_____
Started babbling	_____	Spoke in single words	_____
Spoke in 2-word phrases	_____	Spoke in few-word phrases/sentences	_____
Speech understood by strangers	_____		

Describe peer interactions (interactions with same age children who are not siblings):

_____

_____

School & Services

Name of School _____ District _____

Grade _____ Classroom Type & Size _____

Are any of the following therapies being currently provided?

☐ Physical Therapy ☐ Speech Therapy

☐ Occupational Therapy ☐ Resource Room

☐ Counseling ☐ Other: _____

Has your child ever had any evaluations such as audiology, psychology, or speech/language? ☐ Yes ☐ No

Please send a copy of each evaluation by email or fax.

SLEEP HISTORY

Child usually goes to sleep at _____PM

Does your child fall asleep independently? ☐ Yes ☐ No How long does it take to fall asleep? _____

Does your child sleep through the night? ☐ Yes ☐ No

Child ☐ gets up, *OR* ☐ is wakened at _____AM

Does your child snore – 2 or more times a week? ☐ Yes ☐ No

Does your child maintain a stable bedtime and wake time seven days a week? ☐ Yes ☐ No

Do you have any concerns about your child's sleep? _____

_____

MEDICAL HISTORY

Are your child's immunizations up to date? ☐ Yes ☐ No

Please list any/all operations, hospitalizations (including ER visits), and procedures your child has had:

Where	When	Why

When was your child's last vision screening or evaluation? _____ ☐ Normal ☐ Other _____

hearing screening or evaluation? _____ ☐ Normal ☐ Other _____

Did/does your child have frequent ear infections? ☐ Yes ☐ No

Does your child have

- Poor growth? ☐ Yes ☐ No
- Heart problem? ☐ Yes ☐ No
- Asthma or other respiratory problems? ☐ Yes ☐ No
- Stomach or bowel problems? ☐ Yes ☐ No
- Urine problems? ☐ Yes ☐ No
- Motor weakness or coordination problems? ☐ Yes ☐ No
- Headaches? ☐ Yes ☐ No
- Seizures? ☐ Yes ☐ No
- Anemia or other blood disease? ☐ Yes ☐ No

If you answered 'Yes' to any of questions above, or if your child has any other health care problem/s that are not listed, please explain:

_____

_____

FAMILY & SOCIAL HISTORY

Family Composition

Who lives at home? _____

Mother's highest grade completed _____ Occupation _____

Father's highest grade completed _____ Occupation _____

Please list all other brothers and sisters of child:

Name	Age	Gender
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

Do any other members of the family have problems with attention, behavior, learning, using language, have developmental disabilities including autism, or died from a heart condition prior to the age of 50? ☐ Yes ☐ No

If yes, please explain: _____

_____

*For children **4** years and older* only*:*

Would you say that your child displays the following behaviors?

1. Is "on the go" or "driven by a motor" ☐ Yes ☐ No
2. Has difficulty engaging in quiet activities ☐ Yes ☐ No
3. Fidgets or squirms ☐ Yes ☐ No
4. Has difficulty staying seated ☐ Yes ☐ No
5. Restlessness ☐ Yes ☐ No
6. Runs about and excessively and inappropriately ☐ Yes ☐ No
7. Talks excessively ☐ Yes ☐ No
8. Blurts out answers before questions completed ☐ Yes ☐ No
9. Has difficulty awaiting his or her turn ☐ Yes ☐ No
10. Interrupts or intrudes on others ☐ Yes ☐ No
11. Avoids tasks which require sustained mental effort ☐ Yes ☐ No
12. Has difficulty organizing tasks and activities ☐ Yes ☐ No
13. Has difficulty sustaining attention ☐ Yes ☐ No
14. Does not seem to listen ☐ Yes ☐ No
15. Is easily distracted ☐ Yes ☐ No
16. Is forgetful in daily activities ☐ Yes ☐ No
17. Loses necessary items such as school books and materials ☐ Yes ☐ No
18. Has difficulty following through on instructions from others ☐ Yes ☐ No