PALS Developmental Center

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You must have this packet completed and arrive 15 minutes before your child's appointment to complete additional paper work or your appointment will be canceled.

Dear Parent/Guardian,

Thank you for choosing PALS Developmental Center. We are looking forward to visiting with you and your child. This packet is regarding your first appointment with our office and must be filled out completely to the best of your ability at the time of your appointment or it will be canceled.

The first appointment, will take approximately one hour. Dr. Rogers will spend the majority of her time getting to know your child and understanding your concerns. A comprehensive history and physical examination will be performed. Due to time limitations there will be no intelligence, speech, language, or achievement testing administered during this visit. If developmental or behavioral concerns are present, then screenings with questionnaires will be administered. Further testing may be indicated either through this office, through private testing, or through the local school districts.

What to bring to the first appointment. In addition to this packet it is important to bring your child's latest report card, results of any standardized testing, any previous educational testing, teacher concerns, notes from teachers, previous developmental testing, speech and language evaluations, etc. Any information (provided by the school, daycare, ECI, or physician) is reviewed and is very helpful in deciding if your child has developmental or behavioral problems. All of this information along with Dr. Rogers's observations helps to determine what is causing your child's difficulties.

After our visit, a report will be mailed to you within 3 weeks. No information will be provided to the school by our office. It will be the responsibility of the parent/guardian to share information concerning our visit to the school.

If you have any questions about the fees associated with your first office visit or copay for your insurance please contact our office.

It is important to note that some of the testing performed by this office may not covered by your insurance policy. We will do our best to verify your benefits and eligibility before any additional testing is done but, you are responsible for any fees not covered by your insurance company.

PALS Developmental Center

Patient Information

Name: ____
First Middle Last

DOB: ___________________________ Sex: Male / Female (Circle One)

Social Security Number: ________________________________ (must have for registration)

Address: ____
Street/Box City State Zip

Phone Numbers: ____
Home Cell

Email: ____

Emergency Contact: ____
Name Relationship Phone Number

Race/Ethnicity: ____Caucasian ____Hispanic ____African American ____Other

Primary Care Physician: _________________________Phone Number:__________________

Referring Physician: ____________________________Phone Number:__________________

Family Information

Mother/Guardian Name: _____________________________________ DOB: ____________

Phone Numbers: ____
Home Cell Work

Email: ____

Employer: ______________________________________Occupation:__________________

Father/Guardian Name: ______________________________________ DOB: ____________

Phone Numbers: ____
Home Cell Work

Email: ____

Employer: ______________________________________Occupation: __________________

Additional Children in Family

1.____DOB______________ SEX: M / F

2.____DOB______________ SEX: M / F

3.____DOB______________ SEX: M / F

4.____DOB______________ SEX: M / F

Primary Insurance Information

Name of Person Providing Insurance: ____

Insured's DOB: ____________ Social Security Number: _____________________________

Employer: __________________________________Office Number:___________________

Address: ____
Street/Box City State Zip

Secondary Insurance Information

Name of Person Providing Insurance: ____

Insured's DOB: ____________ Social Security Number: _____________________________

Employer: __________________________________Office Number:___________________

Address: ____
Street/Box City State Zip

RELEASE OF INFORMATION – ASSIGNMENT OF BENEFITS

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF MEDICAL BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT. *I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE BALANCE NOT PAID BY MY INSURANCE CARRIER.*

SIGNATURE: ____DATE:_____________

PALS Developmental Center

Patient History

Patient's Name: ______________________________ Date of Birth: ____________

Your name and relationship to patient: ____

Who were you referred by: ____

Your child attends: Public School Name and contact person:___________________
(circle if applicable) Private School Name and contact person:___________________
Home School Coop or curriculum used:___________________
Day Care Name:___________________________________

Your primary concerns for your child:
____
____

What are your child's strengths?
____

What is difficult for your child? Academics Behavior Both

Past Medical History:
Who is your child's primary care doctor? ______________________________
Is your child allergic to any medicines or foods? No Yes What: _____________
Are your child's immunizations current? No Yes
Is your child on any medications? No Yes What: _____________

Birth History: Please explain for any Yes answers

During pregnancy were there any illnesses or hospitalizations?	No	Yes	
Were there any medications taken during the pregnancy?	No	Yes	
Was there use of alcohol or drug including cigarettes during pregnancy: when and how much?	No	Yes	
Was the child premature?	No	Yes	
Were there any complications during delivery?	No	Yes	Delivered by Vaginal or Caesarean
Was the labor prolonged?	No	Yes	
Were there any medications taken during the delivery?	No	Yes	
What was the child's birth weight?			Birth Weight:

Any of the following complications:			Please explain if yes:
Difficulty breathing?	No	Yes	
Required oxygen or breathing tube?	No	Yes	
Congenital defects?	No	Yes	
Low tone?	No	Yes	
Heart problems?	No	Yes	
Poor feeding or vomiting?	No	Yes	
Jaundice? Treated how?	No	Yes	
Physical injuries?	No	Yes	
Eye problems?	No	Yes	
Did your child pass the hearing screen?	No	Yes	

Has your child ever been hospitalized or visited the emergency room? No Yes
If so please explain:____

Has your child undergone surgery? No Yes
If so please explain:____

Has your child experienced any significant illnesses, injuries, or problems: No Yes
If so please explain (i.e. fractures and/or lacerations): ______________________________

Has your child ever experienced:			If so please explain:
Meningitis?	No	Yes	
Seizures?	No	Yes	
Head trauma with or without loss of consciousness?	No	Yes	
Visual problems or need glasses?	No	Yes	
Hearing problems?	No	Yes	
Feeding problems?	No	Yes	
Heart Problems?	No	Yes	
Respiratory or lung problems?	No	Yes	
Recurrent vomiting or diarrhea?	No	Yes	
Constipation?	No	Yes	
Wetting accidents?	No	Yes	Daytime Night time or Both
Kidney or Liver problems?	No	Yes	
Muscle problems?	No	Yes	
Skin problems?	No	Yes	
Recurrent infections (more than 5 throat, ear, sinus etc. per year)	No	Yes	
History of anemia?	No	Yes	
History of lead poisoning?	No	Yes	
Sleep problems, snoring, apnea or breathing problems while asleep	No	Yes	

Has your child received any therapies? (PT, OT, Speech, Alternative medicine) No Yes
If so please explain:____

Has your child had any previous evaluations for their development or behavior? No Yes
If so please explain

____

____

Developmental History:

When did your child accomplish the following:		Age
Sit without support	Not yet	
Walk alone	Not yet	
Speak first word	Not yet	
Speak in two word or more sentences (Mommy go, Daddy hold, I want cookie)	Not yet	
Ride a bicycle without training wheels	Not yet	
Tie shoes	Not yet	

Family History if Known

Is there anyone in the family with similar problems as your child is experiencing?
Please explain if yes:____

Does anyone suffer from:			If yes who and what:
Mental Retardation or genetic problems?	No	Yes	
Learning Disabilities?	No	Yes	
Attention problems or ADHD/ADD?	No	Yes	
Substance use or abuse?	No	Yes	
Legal difficulties?	No	Yes	
Emotional or mood problems? (Depression, bipolar, anxiety etc.)	No	Yes	
Cardiac Problems	No	Yes	
Hypertension, Diabetes, Lipid problems, Cholesterol problems	No	Yes	
Other?	No	Yes	

Social History: Has your child experienced any significant stresses? No Yes
If so please explain:

____

____

____

Any other information you would like me to know about your child:________________________

____

____

SNAP IV DSM

Patient Name: _____________ Patient DOB:__________ Rater's Name: ___________

Check the ONE Column which best describes this child as compared to his/her peer group:	Not at all	Just a little	Quite a bit	Very much
1. Fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.				
2. Has difficulty sustaining attention in tasks or play activities.				
3. Does not seem to listen when spoken to directly.				
4. Does not follow through on instructions and fails to finish schoolwork, chores, or duties (not due to oppositional behavior or failure to understand).				
5. Has difficulty organizing tasks and activities.				
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).				
7. Loses things necessary for task or activities (e.g. school assignments, pencils, books, or toys).				
8. Is easily distracted by extraneous stimuli.				
9. Is forgetful in daily activities.				
10. Fidgets with hands or feet or squirms in seat.				
11. Leaves seat in classroom or in other situations in which remaining seated is expected.				
12. Runs about or climbs excessively in situations in which remaining seated is expected.				
13. Has difficulty playing or engaging in leisure activities quietly.				
14. Is always "on the go" or "driven by a motor".				
15. Talks excessively.				
16. Blurts out answers to questions before the questions have been completed.				
17. Has difficulty waiting in lines or awaiting turn in games or group activities.				
18. Interrupts or intrudes on others (e.g. butts into other's conversations).				
19. Loses temper.				
20. Argues with adults.				
21. Actively defies or refuses to comply with adults' requests or rules.				
22. Deliberately annoys people.				
23. Blames others for his or her mistakes or misbehavior.				
24. Is touchy or easily annoyed by others.				
25. Is angry or resentful.				
26. Is spiteful or vindictive.				

Totals: Inattention (Items 1-9): _____/9 (>6)
Hyperactivity (Items 10-18): _____/9 (>6)
Oppositionality (Items 19-26): _____/8 (>4)

Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

	NEVER (0)	SOMETIMES (1)	OFTEN (2)
1. Complains of aches and pains ------------------------	1._________	_____________	____________
2. Spends more time alone --------------------------------	2._________	_____________	____________
3. Tires easily, has little energy --------------------------	3._________	_____________	____________
4. Fidgety, unable to sit still -------------------------------	4._________	_____________	____________
5. Has trouble with teacher --------------------------------	5._________	_____________	____________
6. Less interested in school --------------------------------	6.__________	_____________	____________
7. Acts as if driven by a motor ----------------------------	7.___________	_____________	____________
8. Daydreams too much ------------------------------------	8.___________	_____________	____________
9. Distracted easily --	9.___________	_____________	____________
10. Is afraid of new situations -----------------------------	10.__________	_____________	____________
11. Feels sad, unhappy -------------------------------------	11.__________	_____________	____________
12. Is irritable, angry --	12.__________	_____________	____________
13. Feels hopeless --	13.__________	_____________	____________
14. Has trouble concentrating -----------------------------	14.__________	______________	____________
15. Less interested in friends -----------------------------	15.__________	______________	____________
16. Fights with other children -----------------------------	16.__________	______________	____________
17. Absent from school -------------------------------------	17.__________	______________	____________
18. School grades dropping --------------------------------	18.__________	______________	____________
19. Is down on him or herself------------------------------	19.__________	______________	____________
20. Visits the doctor with doctor finding nothing wrong	20.__________	______________	____________
21. Has trouble sleeping -----------------------------------	21.__________	______________	____________
22 Worries a lot --	22.__________	______________	____________
23. Wants to be with you more than before ------------	23.__________	______________	____________
24. Feels he or she is bad-----------------------------------	24.__________	______________	____________
25. Takes unnecessary risks --------------------------------	25.__________	______________	____________
26. Gets hurt frequently ------------------------------------	26.__________	______________	____________
27. Seems to be having less fun --------------------------	27.__________	______________	____________
28. Acts younger than children his or her age ---------	28.__________	______________	____________
29. Does not listen to rules---------------------------------	29.__________	______________	____________
30. Does not show feelings --------------------------------	30.__________	_____________	____________
31 Does not understand other people's feelings -------	31.__________	______________	____________
32. Teases others ---	32.__________	______________	____________
33. Blames others for his or her troubles ---------------	33.__________	______________	____________
34. Takes things that do not belong to him or her -----	34.__________	______________	____________
35. Refuses to share ---	35.__________	______________	____________

Total score _____

Does your child have any emotional or behavioral problems for which she/he needs help?------------ __No __Yes

Are there any services that you would like your child to receive for these problems? ----------------- __No __Yes

If yes, what type of services? ____

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English PSC Gouverneur Revision 01-06-03