Main Office:
6602 Waters Avenue, Building C
Savannah, Georgia 31406
Telephone (912) 354-7676
Fax (912)354-2181

Richmond Hill
9665 Ford Avenue
Richmond Hill, GA 31324

Effingham Co. Hospital Physicians Center
459 Hwy 119 South
Springfield, GA 31329

Pediatric Office (Dr.'s Pearlman and Moretz)
720 E. 71st Street
Savannah, GA 31405

Richard A. Bodziner, MD
Jessica F. Carter, MD
William T. Garrett, MD
Joel A. Greenberg, MD
J. Michael Hemphill, MD
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Katherine Moretz, MD
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Amanda B. Merritt, MSN, APRN, ANP-BC
Angie R. Moye, MSN, APRN, FNP-BC
Wallette G. Widener, MSN, APRN, FNP-BC

Welcome,
You are scheduled for an appointment with our office on: ______________________________ at _________________________.

If you are unable to keep your appointment please give us 48-hour notice.

The following paperwork is enclosed and <u>must</u> be completed prior to arrival at the office:
- Patient information
- Financial Policy and Release of Information
- Private Policy Form
- Medical History Form

Please be sure to bring ALL of the following to your appointment. Failure to do so may result in the rescheduling of your appointment.
- Insurance cards and picture ID
- All current medications
- Copy of any diagnostic imaging studies (X-ray, MRI, CT-scan, etc...)
- Any referrals and/or authorizations required in order to process insurance.
- Co-pays and deductibles to be collected at each visit.

Please bring or have your referring physician send all medical records to our office including diagnostic testing, EEG reports and laboratory findings.

☑ **Please fill out in BLACK or BLUE ink.**
☑**Please do not mail the packet back.** Bring the completed paperwork on the day of your appointment.

If you have any questions regarding the enclosed information or office procedures, please do not hesitate to call us at (912) 354-7676.

We look forward to having you as a patient!
Savannah Neurology Specialists Physicians and Staff

Insurance and Injury Questionnaire

All patients are <u>required</u> to answer the following questions.

We file insurance as a courtesy to our patients, however, the following must be filled out in order to process your claim.

Patient Name: ______________________________ Date of Birth:__________________

Primary Insurance (A copy of your insurance card is required)
If Workers' Compensation, please skip this section
Insurance Carrier: ______________________________ ID#: ________________________________
Group #: ________________________ Policy Holder (if other than patient): ______________________
Date of Birth: _____/_____/_____ SSN: ________________ Relationship to Patient: __________________

Secondary Insurance (A copy of your insurance card is required)
Insurance Carrier: ______________________________ ID#: ________________________________
Group #: ________________________ Policy Holder (if other than patient): ______________________
Date of Birth: _____/_____/_____ SSN: ________________ Relationship to Patient: __________________

Are you receiving Black Lung Benefits? YES NO

Are you receiving Worker's Compensation Benefits? YES NO

Are you receiving treatment for an injury or illness which another party could be held liable or could be covered under no-fault or auto insurance? YES NO

Will this claim be filed with any other insurance such as homeowners or business liability, etc? YES NO

Signature: ______________________________Date:__________________________

☑*<u>Only if you answered YES</u> to any of the above questions, please complete the following:*

Name of Workers Compensation, Black Lung, Auto Insurance, Homeowners or Business Liability Insurance Co:
____
Claim/Policy #: ______________________________ Date of Injury: ______________
Adjustor Name: ______________________________ Adjustor Phone: _____________
Adjustor Fax: ________________________________

Do you have any other insurance other than what you have listed above that you would like to be filed on this claim? YES NO

If yes, please list information below:
Name of Insurance Company: ____
Address: ____
Insured: ____
Policy #: ________________________________ Group #: ____________________

Savannah Neurology Specialists, P.C.
6602 Waters Avenue - Bldg. C
Savannah, GA 31406
Tel: (912) 354-7676

PATIENT REGISTRATION (Please print clearly in BLACK or BLUE ink only.)

Name: ______________________ Date of Birth: ____/____/____ SSN: ______________

Please circle all that apply: (These questions are required by the Federal Government to meet Meaningful Use Guidelines-you may decline to answer by circling DECLINED in each column.)

Marital Status:	**Race:**	**Ethnicity:**	**Sex:**	**Religion:**
Married	American Indian/Alaska Native	Hispanic/Latino	Male	Buddhist
Single	Asian	Not Hispanic/Latino	Female	Catholic
Divorced	Black/African American	Declined		Hindu
Separated	Native Hawaiian/Pacific Islander			Islam
Widowed	White			Jehovah's Witness
Declined	Other: ________			Jewish
	Declined			Mormon
				Protestant
				Other: ________

Primary Language: ______________________

Mailing Address: ______________________________ Apt. ________

City: ______________________ State: ____________ Zip: ________

Home #: ______________ Cell #: ______________ Work #: ______________

Preferred Phone: ☐ home ☐ work ☐ cell Ok to leave message at home? ☐ yes ☐ no/ at work? ☐ yes ☐ no/ on cell? ☐ yes ☐ no

Email: ______________________ Employer: ______________________

Referring Physician: ______________________ Primary Care Physician: ______________________

Some insurances have a required pharmacy, hospital and/or lab. Please fill out your required or preferred location for:
Pharmacy: ______________ Hospital: ______________ Lab: ______________

If Patient is a minor or dependent, please complete the following information:

Responsible Party: ______________________ Date of Birth: ______________
SSN: ______________________ Relationship to Patient: ______________
Home #: ______________ Cell #: ______________ Work#: ______________
Address: ______________________ City: ______________ State: ______ Zip: ________

EMERGENCY CONTACT (other than Responsible Party):

Name: ______________________ Relationship to Patient: ______________

Home #: ______________ Work #: ______________ Cell #: ______________

Patient Acknowledgment

I consent to treatment necessary for the care of the above named patient.
I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
I allow fax transmission of my medical records, if necessary.
I acknowledge full financial responsibility for services rendered by Savannah Neurology Specialists, PC.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I agree to pay all attorney fees and collection costs in the event of default of payment of my charges.
I further authorize and request that insurance payments be made directly to Savannah Neurology Specialists should they elect to receive such payment.
I understand that I may withdraw this authorization to release medical information at any time, communicated to the practice either in writing or verbally, followed by written withdrawal.

Patient or Responsible Party Signature: ______________________ **Date:** ______________

Savannah Neurology Specialists, PC
Financial and Treatment Policy

Thank you for choosing Savannah Neurology Specialists. In order to keep your costs as low as possible, we have the following financial policy in place. *All patients are required to read and sign this document prior to their first visit.*

Before your appointment, please verify that we are a participating provider in your insurance plan and obtain any necessary authorizations. Our contracts with insurance plans require that we collect any co-payment, co-insurance or deductible due before you are seen for your appointment, unless other arrangements have been made prior to your appointment. Failure to pay a fee due prior to your appointment may result in the rescheduling of your appointment. You will be financially responsible for any services provided that are not covered by your insurance. For patients without insurance coverage, all professional services rendered are charged to the patient and are due at the time of service, unless prior arrangements are made.

Insurance carriers typically do not cover all medical costs. Some pay fixed allowances for each procedure and office visit, while others pay only a percentage of the costs. Procedures, labs, and other outpatient procedures may have a higher co-payment or fall under the deductible. It is the patients responsibility to understand their insurance coverage and to notify us of any changes.

When you receive a statement from Savannah Neurology Specialists, you are required to pay the balance due upon receipt of the statement. Those accounts not paid in full within 90 days and no acceptable payment arrangement has been agreed upon will be turned over to an outside collection service. Accounts turned over to outside collection services are subject to an administrative fee of 15% of the account balance.

Acceptable forms of payment are cash, check, and all major credit cards. Please note, if you pay with a check that is returned unpaid by your bank, your account will be charged a service fee of $30. We will bill you for the amount of the returned check plus the service fee according to the policy stated above.

If the patient is a minor, the adult accompanying the patient and the parents or guardians of the patient are responsible for full payment.

Patient Name (PLEASE PRINT) ______________________________

Signature of Patient or Responsible Party ______________________ Date ______________

Savannah Neurology Specialists, PC
6602 Waters Avenue, Building C
Savannah, Georgia 31406
(912) 354-7676 Phone
(912) 354-7181 Fax

ACKNOWLEDGEMENT OF THE PRIVACY ACT OF 2007
PATIENT RECORD OF DISCLOSURE

In general the HIPPA privacy rules give individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home via mail or fax.

I have agreed to let certain individuals participate in discussions and decisions related to my medical care, including but not limited to prescription pick-up and the release of medical records. Therefore, I hereby give permission for Savannah Neurology to disclose my personal medical information to the following individual(s). **I understand that Savannah Neurology Specialists will refuse to discuss my information with anyone not listed below, except in an emergency.** I also understand that this consent does not apply to medical providers in the treatment of my care. *This form can be amended at any time if the patient/responsible party completes and signs a new form.*

Name: ___________________________________ Relationship to Patient: _________________________________

Name: ___________________________________ Relationship to Patient: _________________________________

Name: ___________________________________ Relationship to Patient: _________________________________

Name: ___________________________________ Relationship to Patient: _________________________________

In addition to granting permission to the above named individuals, I have received a copy of the Savannah Neurology Specialists **"Notice of Privacy Practices"** which details how my personal health information may be used and disclosed as permitted under Federal and State law. I have read and understand the contents of the notice.

____ ____

Print Patient's Name **Date**

____ ____

Signature of Patient or Responsible Party **Witness**

STAFF ONLY:
If a patient/representative refuses to sign this acknowledgment of Receipt, please document why including the date and time.

____

Presented and Refused Reason **Name/Title/Date/Time**

NOTICE OF PRIVACY POLICIES
Savannah Neurology Specialists, P.C.

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction
At Savannah Neurology Specialists, P.C., we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective April 10, 2010, updated September 15, 2013.

Understanding Your Health Record/Information
Each time you visit Savannah Neurology Specialists, P.C. a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights
Although your health record is the physical property of Savannah Neurology Specialists, P.C., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record.
- Request that your record be amended.
- Obtain an accounting of disclosures of your health information: To do this, please contact Savannah Neurology Specialists, P.C.'s Privacy
- Officer. This information will be provided to you within 30 days.
- Request a restriction on certain uses and disclosures of your information.
- Revoke your authorization to use or disclose your health information.
- You may request that we not submit your information to your heath insurance carrier if you have paid for the service.
- You may request an electronic copy of your health record.
- You have the right to restrict certain disclosures to your health plan when you pay for the treatment in question in full.

Our Responsibilities
Savannah Neurology Specialists, P.C. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice about our privacy practices,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- We must notify you of a breach of unsecured health information.

We will not use or disclose your health information without your authorization, except as described in this notice. To revoke your authorization, please put your request in writing to Savannah Neurology Specialists, P.C.

For More Information or to Report a Problem
If you have questions and would like additional information, you may contact the practice's Privacy Officer at (912) 354-7676.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations
We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your other physicians or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person
you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives of other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

6602 Waters Avenue, Building C, Savannah, GA · 912.354.7676

History and Physical

Patient Information

Name: ________________________________ Today's Date: ___/___/___ Preferred Pharmacy: ___________________

Date of Birth: ___/___/___ Age:______ Occupation: ___________________________ How many years? ____________

Referring Doctor: _____________________________ Primary Care Doctor: ___________________________________

Are you **Right-handed** or **Left-handed?** (please circle)

Chief Complaint

How would you describe your problem/reason for your visit? ____

____

History of Present Illness

When did your problem start? ___________________________ Is it getting: **BETTER/WORSE/SAME**

Have you seen another Doctor for this problem? **YES/NO** If yes, what Doctor and when? _________________________

Have you had any testing for this problem? **YES/NO** (x-ray, MRI, CT, EMG, EEG, lab work)
If yes, where? ____ When?_____________________________________

Past Medical History

Have you ever been diagnosed or treated for any of the following conditions? (Please circle all that apply)

Asthma
Allergies *
Alzheimer's Disease
Aneurysm *
Arthritis
Anemia
Anorexia/Bulimia
ADD / ADHD
Anxiety
Balance Trouble
Bi-Polar Disorder
Cancer *
Carpal Tunnel Syndrome
Cerebral Palsy
Cirrhosis

Chronic Lung Disease
Depression
Diabetes
Dizziness/Vertigo
Dementia
Drug Abuse *
Ear Infections
Emphysema
Eye Disease *
Epilepsy/Seizures
Fainting/Syncope
Fibromyalgia
Glaucoma
Hallucinations *
Headaches

Head Injury *
Heart Disease
Heart Attack
Hepatitis
High Cholesterol
High / Low Blood Pressure
Implant/Pacemaker
Low Blood Sugar
HIV Positive
Hearing Changes*
Kidney Condition*
Meningitis
Mental Retardation

Mental Illness *
Muscle Condition*
Multiple Sclerosis
Obsessive Compulsive Disorder
Osteoporosis
Osteopenia
Parkinson's Disease
Prostate Condition *
Ringing in ears/Tinnitis
Spine Disorder *
Stroke/Pin

Stroke/TIA
Swelling Arms/Legs
STD *
Skin Condition *
Suicidal Thoughts
Thyroid Disease
Tremors/Shaking
Urinary/Bowel Conditions *
Visual Disturbances
Vascular Conditions *

*Other/Please explain:

Do you have an implant? **YES/NO** If yes, please explain: ____

Do you have a pacemaker? **YES/NO** If yes, please explain: ____

Previous hospitalizations/surgeries:

Reason: Date: Location:

1. ____
2. ____
3. ____
4. ____
5. ____

GYN:

Date of last menstrual period: _______________ Are your periods regular? YES/NO

Number of births: _________ Number of pregnancies: _________ Number of miscarriages: ________

Medications: please list all prescriptions/vitamins/birth control/over the counter/herbal supplements, their dosage and how many times you take per day.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

Drug Allergies: please include the name of the medication and reaction.

1. ____
2. ____
3. ____

Family History:

Please mark any major medical conditions that run in your immediate family (Mother, Father, Maternal/Paternal Grandparents, Aunt, Uncle, Brother, Sister) and indicate your relationship to that person.

	Condition:	Relative:		Condition:	Relative:
	Asthma			Headache/Migraine	
	Arthritis			Heart Attack/Disease	
	Cancer			High/Low Blood Pressure	
	Cerebral Palsy			Mental Illness	
	Dementia/Alzheimer's			Mental Retardation	
	Diabetes			Muscle Disease	
	Epilepsy/Seizures			Sickle Cell Disease	
				Stroke	
				Thyroid Disease	

Father: Living/Deceased Age of Death: ________ Medical Problems: ____________________________________

Mother: Living/Deceased Age of Death: ________ Medical Problems: ____________________________________

Siblings: Living/Deceased Age of Death: ________ Medical Problems: ____________________________________
Living/Deceased Age of Death: ________ Medical Problems: ____________________________________
Living/Deceased Age of Death: ________ Medical Problems: ____________________________________
Living/Deceased Age of Death: ________ Medical Problems: ____________________________________

Social History: (Age 13 through Adults only. Pediatric patients go to next section.)

Are you (circle one): **Married** **Single** **Divorced** **Separated** **Widowed**

Do you smoke? **YES/NO** If yes, amount? ______________________ How often? _______________________
Have you smoked/used tobacco products in the past? If yes, amount? ____________ How often? __________________

Do you drink alcoholic beverages? **YES/NO** If yes, amount? _________________ How often? _________________

Do you use recreational/illegal drugs? **YES/NO** If yes, what type? ____
How often ? ________________________________

Do you drink caffeinated beverages? **YES/NO** If yes, what type? ___________________ How often? ______________

Do you exercise regularly? **YES/NO** Please explain: ____

Do you currently practice any diet restrictions? **YES/NO** **(Please circle all that apply):**
Low Sugar/Low Sodium/Low Fat/Low Carb/Cardiac diet/ Neutropenic diet/Vegetarian/Diabetic diet/Weight loss diet/ Ketogenic/Gluten Free/Dairy Restricted

Have you ever been a victim of physical abuse resulting in injuries? **YES/NO** Please explain: _____________________
____

Have you ever had a motor vehicle accident resulting in injuries and/or a lawsuit? **YES/NO** Please list dates and injuries:
____

Have you ever had any other type of accident or injury we should be aware of? **YES/NO** ________________________
____

Are there any unusual stress or safety issues we should be aware of? **YES/NO** ________________________________

Review of Systems: Please circle any symptoms you have experienced in the past MONTH.

General:
Altered Taste/Smell
Change in Appetite
Weight Loss
Weight Gain

Ears/Nose/Mouth/Throat:
Changes in hearing
Ringing in ears
Recent sinus infection
Snoring
Nose bleeds
Mouth sores
Difficulty swallowing or choking

Eyes:
Cataracts
Drooping Eyelids
Glaucoma
Changes in vision
Vision correction (glasses, etc)
Blurred/double vision

Respiratory:
Asthma
Shortness of breath
Wheezing
Cough
Pneumonia
Upper Respiratory Infections
Tuberculosis

Cardiac:
Chest discomfort
Cold hands and/or feet
Discoloration of hands/feet
Swelling of extremities
Heart murmurs
High blood pressure
Heart palpitations

Gastrointestinal:
Abdominal pain or swelling
constipation
diarrhea
hemorrhoids
heartburn
nausea
Vomiting

Genital/Urinary:
Prostate Problems
Sexually transmitted disease
Sexual Dysfunction
Changes in urinary habits
Recent urinary infection
Kidney stones
Incontinence

Skin/Breast/Chest:
Breast changes/discharge
Changes in skin color
Yellowing of the skin
Rash
Itching
Skin Pain/Sores

Psychiatric:
Personality changes
Compulsive behavior
Depression
Hostility
Nervousness
Restless
Anxiety
Hallucinations
Mood Swings
Sleep Disturbances
Increased Stress
Unusual Behavior

Endocrine:
Changes in hair
Excessive hunger/thirst
Increase/change in body odor
Intolerance to heat/cold

Hematologic/Lymphatic:
Anemia
Easy bleeding/bruising
Swollen lymph nodes

Neurological:
Problems walking/balance
Numbness
Tingling Sensations
Burning Sensations
Decreased touch sensation
Confusion/disorientation
Seizures
Falls
Lack of Coordination
Muscle weakness
Back/Neck Pain
Tremors
Blackouts/fainting
Memory Loss
Excessive drowsiness
Tics
Dizziness/Vertigo
Lightheaded
Loss of consciousness
Speech Difficulties
Changes in concentration
Staring Spells
Headache/Migraine

Allergic/Immunologic:
Problems with Immunity
Seasonal Allergies

Notes:

☐ Above reviewed and discussed with patient **☐ All Systems Negative**

____
Patient Signature

____
Physician Signature

____
Parent/Guardian Signature (if patient is minor)

____
Date

Pediatric Questionnaire
(Adult Patients can skip this section.)

Prenatal Care and Delivery:

How old was the mother at delivery? ________ Birth Order (1st, 2nd, etc..) _________ Number of pregnancies _______

Live Births: ______ Miscarriages/Abortions _______ Any complications with pregnancy or delivery? ______________

Medications during Pregnancy? ____

Any drug or alcohol use during pregnancy? **YES/NO** How long was labor? _________________________________

Was medication used to induce labor? **YES/NO** Was the baby premature? **YES/NO** #of weeks: ___________

Please circle:

Vaginal Delivery	Forceps used	General Anesthesia
Breach Birth	Vacuum used	Epidural
C-section		

Was there a delay in breathing or crying? YES/NO Did the baby need assistance breathing? YES/NO
Was the baby in Special Care Nursery? YES/NO
Hospital the baby was delivered in? _________________________ How long was the baby hospitalized? _____________
Birth weight: ________________ APGAR scores: _____________ Was the baby a poor feeder? YES/NO

Developmental Milestones/Motor Skills:

Please indicate the approximate age your child did the following:

Smile ______ Say “ma-ma/da-da” ______ Wave bye-bye ______ Drink from cup without lid ______
Say 2 word sentences ______ Roll over ______ Sit Alone ______ Crawl ________ Walk Alone _________

Is your child's development similar to that of siblings? YES/NO
Do you feel that your child is able to do the same skills of other children their age? YES/NO

Behavior:

How does your child play with other children? ____

Are there any behavior problems at home or in school? YES/NO Explain: ______________________________________

Is your child easily distracted or inattentive? YES/NO Explain: ____

Do you feel that your child is more withdrawn or moody than other children his age? YES/NO
Explain: ____

Does your child exhibit any unusual behaviors such as rocking, head banging or hitting themselves? YES/NO
Explain: ____

What are your child's current grades in school? (Please circle) A's B's C's D's F's
Comments: ____

Are there any subjects your child has difficulty with?)____

Does your child receive any special services or therapies such as: speech, physical or occupational therapy, Children's Medical Services, PSU, or Special Education classes in school? YES/NO
Describe: ____

Does your child require the use of any assistive devices or medical equipment? YES/NO
Describe: ____

Personal/Social History:

Who lives in the home with the child? Please list relationship and age of each person.

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

Name of school child attends: ____________________________________ Grade: __________________________

Recreational Activities? YES/NO Describe: ____

Does your child practice diet restrictions? YES/NO Describe: ____

Has your child ever been a victim of physical abuse resulting in injuries? YES/NO Explain: ____________________

____

Has your child ever been involved in a motor vehicle accident resulting in injuries? YES/NO Explain: ____________

____

Has your child had any other type of accident or injury that we should be aware of? YES/NO Explain: ____________

____

Are there any unusual stress or safety issues we should be aware of? YES/NO Explain: _______________________

____

Name/Relationship of person completing this form: ____

______________________________________ ______________________________________
Signature of Responsible Party Date