Children's Hospital
New Orleans
LCMC Health

Informed Consent for Psychotropic Medication Treatment for your child: Understanding of Clinical Treatment Guidelines and Collaboration between Medical Psychologist and Physician

Your child will be seen by a Medical Psychologist (Mayling Walker, PhD, MP or Michelle Niemeier, PhD, MP) for the purposes of medical/ psychopharmacological intervention (meaning psychological treatment with medication, if indicated). The Medical Psychologist will manage any psychotropic medications he/she has prescribed for your child. The Medical Psychologist will work in collaboration and in concurrence with your child's referring or attending physician.

Your child will undergo an evaluation by a Medical Psychologist. If your child meets classification criteria, he or she will be diagnosed accordingly based on the current guidelines of Diagnostic and Statistical Manual of Mental Disorder, 5th Edition (DSM-5). This process typically considers information provided to the doctor via a diagnostic interview, behavioral observations, and data obtained from laboratory and psychological instruments. A diagnosis may be updated or changed, consistent with standards of care and any pattern of emerging and clinically valid evidence.

The medical psychologist's diagnostic impressions and treatment recommendations will be communicated with the parent/caregiver. If pharmacological interventions are recommended as part of the treatment plan, a decision to medicate your child will be made collaboratively between parents/caregivers and the medical psychologist in an effort to improve your child's functioning. Medications can reduce or alleviate symptoms, but do not cure illnesses. The goal of treatment is to maximize benefits and minimize risks.

The medical psychologist will carefully review the medication(s) with the parent/caregiver and provide information about potential side effects. Please understand that in certain situations, taking medication may cause physical and emotional discomfort to your child, could worsen your child's condition, or in rare instances, may even cause more serious complications such as potential misuse, abuse, or addiction and dependency; permanent damage; or death. Many prescribed medications do not have FDA-approval specifically for use in children.

You are expected to work closely with your prescribing doctor and understand it is your responsibility to discuss the effects the medication is having on your child so that he/she can continue to assist the parent/caregiver in ensuring the health and progress of the child's development. Please make sure that your child has taken his/her prescribed medication(s) at each follow-up appointment with the medical psychologist so that vital signs can be monitored.

Notify your doctor in advance before personally making any changes to the agreed-upon treatment plan, including adjusting dosages and/or discontinuation of use, so that any changes will be made with the doctor's approval and supervision. This is done to ensure your child's safety. Inappropriate drug discontinuation can pose serious problems.

CHILDREN'S HOSPITAL

Appointment and Cancellation Policy

DEPARTMENT OF PSYCHOLOGY

200 Henry Clay Avenue • New Orleans, LA 70118 • (504) 899-9511 • www.chnola.org

No shows, last minute cancellations, and late arrivals are disruptive to your child's care and your clinician's schedule. Below are the policies that have been implemented regarding these situations:

* New patients who no show for their first appointment, regardless of type (e.g., evaluation, therapy, medication management), will not be rescheduled automatically. Patients who no-show initial appointments must contact our office to reschedule appointments.
* Cancellations must occur at least 24 hours in advance of your appointment. Last minute cancellations (within 24 hours) and no shows are discouraged. If you cancel last minute or no show for **two** appointments, regardless of appointment type, services will be discontinued.

ADDITIONAL POLICIES:

Outpatient Therapy:

- Please arrive for your child's appointment at or before the specified time. Patients are scheduled hourly and a late arrival will shorten your appointment length. If you arrive **15 minutes** after the scheduled appointment time, you will be required to reschedule. Rescheduling in this manner will be considered a no show.
- If you cancel in advance for **two** appointments, you are at risk for a discontinuation of service. We will discuss strategies to ensure future attendance at that time. An additional (**third**) advance cancellation will result in termination of service.

Rapid Treatment Program – New Patients:

- Please arrive for your child's appointment **30 minutes before** your specified appointment time. All paper work must be completed upon your arrival. If you arrive **15 minutes** after the scheduled appointment time and/or **paperwork is not complete**, you may be required to reschedule. Rescheduling in this manner will be considered a no show.

Rapid Treatment Program Medication Management – 30 minute appointments:

- If you arrive **10 minutes** after the scheduled appointment time and/or **paperwork is not complete**, you may be required to reschedule. Rescheduling in this manner will be considered a no show.

Evaluation Appointments (neuropsychological testing, psychological testing, Autism Spectrum Disorder testing):

- Please arrive for your child's appointment **30 minutes before** the specified time (e.g., 8:30 AM for a 9 AM appointment). If you arrive **15 minutes** after the scheduled appointment time (e.g., 9:15 AM for a 9 AM appointment) and/or your **paperwork is not complete**, you may be required to reschedule. Rescheduling in this manner will be considered a no show.

If I have any questions regarding this information, I understand that I may call (504) 896-9484 or inquire during session.

I understand and agree with the above described policy.

Print Patient's Name

Parent/Guardian's Signature **Date**

X / /

CHILDREN'S HOSPITAL

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

All areas designated by an ➡ are REQUIRED for valid authorization.

PLACE PATIENT'S LABEL HERE

1 *I authorize* ➡ NAME OF HOSPITAL / PHYSICIAN: **Children's Hospital, New Orleans /** ☐ *to receive from* ☐ *to release to*

2 ➡ SPECIFIC NAME OF HOSPITAL, PHYSICIAN, SERVICE AGENCY OR THIRD PARTY

3 ➡ STREET ADDRESS | CITY | STATE | ZIP CODE

☐ *Mail* ☐ *Email :* _____

Patient's Name: _____

Patient's Date of Birth: _____

Service Dates: _____

4 ➡ ***I AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION:***

☐ Abstract (H&P, OP, DS, Rad, Lab, Con)	☐ Complete Hospital	☐ History and Physical Report (H&P)
☐ Adolescent Behavioral Health	☐ Consultation(s) (Con)	☐ Lab Reports (Lab)
☐ Audrey Hepburn CARE Center	☐ Diagnosis, including alcohol and drug abuse	☐ Radiology Results (Rad)
☐ Billing Information	☐ Discharge Summary (DS)	☐ Results of HIV testing
☐ Clinic Notes	☐ Emergency Room Record (ER)	☐ Report of Operation (OP)
☐ Complete Clinic Record		
☐ Other: _____		

5 ➡ *I AUTHORIZE the release of HIV test results. I understand I am authorized by law to allow or refuse to allow the release of HIV Test Results. An HIV Test Result is the original document, or copy thereof, transmitted to the medical record from the laboratory or other testing site with the result of an HIV-related test. It does not include any other note, notation, diagnosis, report, or other writing or document.*

☐ **I AUTHORIZE** the release of HIV test results. ☐ **I DO NOT AUTHORIZE** the release of HIV test results.

6 ➡ ***This information is to be released for the purpose of:***

☐ Continuation of care ☐ Treatment in the facility indicated above ☐ Legal services ☐ Academic Case Study/Journal Story
☐ Insurance request ☐ Other (please specify purpose) _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 42.164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the hospital's Privacy Officer.

7 ➡ *Signature(s) & Date(s) Required*

Patient, Parent/Guardian of Minor or Legal Representative Signature X		**Phone Number**
Relationship to Patient or Title of Legal Representative	**Date** MM/DD/YY / /	**Time** 00:00 am/pm : AM PM
Witness Signature X	**Date** MM/DD/YY / /	**Time** 00:00 am/pm : AM PM

☐ *Electronic Media Requested* ☐ *Language Line:* ☐ *Declined* ☐ *Interpreter's #* _____

☐ *CD Processed Name:* _____ *Date:* _____

☐ *Scan to PT Auth*

RELEASE OF INFORMATION
Authorization for Records

R10020

CHILDREN'S HOSPITAL

UTORIZACIÓN PARA LA DIVULGACIÓN DE INFORMACIÓN CONFIDENCIAL

Todas las áreas designadas por un ➡ son REQUERIDAS para la autorización válida.

PLACE PATIENT'S LABEL HERE

1 *Autorizo a* ➡ NOMBRE DEL HOSPITAL / PHYSICIAN: **Children's Hospital, Nueva Orleans /** ☐ *a recibir de* ☐ *a divulgar a*

INFORMACIÓN SOBRE:

2 ➡ NOMBRE ESPECÍFICO DEL HOSPITAL, MÉDICO, AGENCIA DE SERVICIO O TERCERO

3 ➡ DIRECCIÓN FÍSICA | CIUDAD | ESTADO | CÓDIGO POSTAL

☐ *Correo* ☐ *Correo electrónico* : _____

Nombre del paciente: _____

Fecha de nacimiento del paciente: _____

Fechas de servicio: _____

4 ➡ ***AUTORIZO LA DIVULGACIÓN DE LA SIGUIENTE INFORMACIÓN***

☐ Abstracto (H&P, OP, DS, Rad, Lab, Con) (H&P, OP, DS, Rad, Lab, Con)	☐ Hospital completo	☐ Historial e Informe físico (H&P)
☐ Salud conductual de adolescentes	☐ Consulta(s) (Con)	☐ Informes de laboratorio (Lab)
☐ Centro CARE de Audrey Hepburn	☐ Diagnóstico, incluyendo el abuso del alcohol y de drogas	☐ Resultados de radiología (Rad)
☐ Información de facturación	☐ Resumen del alta (DS)	☐ Resultados de la prueba del VIH
☐ Notas clínicas	☐ Registro de Sala de urgencias (ER)	☐ Informe de operación (OP)
☐ Otros: _____		

5 ➡ *Yo AUTORIZO la divulgación de los resultados de la prueba del VIH. Entiendo que estoy autorizado por la ley para permitir o negarme a permitir la divulgación de los resultados de la prueba del VIH. Un resultado de la prueba del VIH se trata del documento original, o una copia del mismo, transmitido al expediente médico por el laboratorio u otro sitio que realice tales pruebas y que contenga el resultado de una prueba del VIH. No incluye ninguna otra nota, notación, diagnóstico, informe, u otra escritura o documento.*

☐ Yo AUTORIZO la divulgación de los resultados de la prueba del VIH ☐ Yo NO AUTORIZO la divulgación de los resultados de la prueba del VIH.

Esta información es para ser divulgada con el fin de:

6 ➡

☐ Continuación de cuidado ☐ Tratamiento en el centro médico indicado anteriormente ☐ Servicios legales

☐ Estudio de caso académico/Artículo de gaceta ☐ Solicitud de seguro

☐ Otro (por favor especifique el propósito) _____

Entiendo que tengo el derecho de revocar esta autorización en cualquier momento. Entiendo que si revoco esta autorización debo hacerlo por escrito y presentar mi revocación escrita al Departamento de registros médicos. Entiendo que la revocación no se aplicará a la información que ya ha sido divulgada en respuesta a esta autorización. Entiendo que la revocación no se aplicará a mi aseguradora cuando la ley le otorga a mi aseguradora el derecho de contestar una reclamación bajo mi póliza. A menos que se revoque de otra forma, esta autorización vencerá en la siguiente fecha, evento o condición: _____. Si yo omito especificar una fecha de vencimiento, evento o condición, esta autorización se vencerá dentro de un año. Entiendo que la autorización para la divulgación de esta información médica es voluntaria. Puedo rehusar a firmar esta autorización. Yo no necesito firmar este formulario para asegurarme de recibir el tratamiento médico. Entiendo que puedo inspeccionar o copiar la información a ser usada o divulgada según se establece en CFR 42.164.524. Entiendo que cualquier divulgación de información conlleva la posibilidad de una nueva divulgación no autorizada y la información puede no estar protegida por las reglas federales de confidencialidad. Si tengo preguntas sobre la divulgación de mi información médica, puedo consultar al Oficial de privacidad del hospital.

7 ➡ *Firma(s) y fecha(s) requeridas*

Firma del Paciente, padre o tutor del menor o Representante Legal **X**		Número de teléfono
Relación con el paciente o el título de Representante Legal	Fecha MM/DD/YY / /	Hora 00:00 am/pm : AM PM
Firma de testigo **X**	Fecha MM/DD/YY / /	Hora 00:00 am/pm : AM PM

☐ *Medios electrónicos solicitados* ☐ *Línea de idioma:* ☐ *Rechazado* ☐ *Número de intérprete* _____

☐ *Nombre del CD procesado:* : _____ *Fecha:* _____

☐ *Escán a PT Auth*

DIVULGACIÓN DE INFORMACIÓN
Autorización para registros

RI0020

RAPID TREATMENT PROGRAM CONSENT

PLACE PATIENT'S LABEL HERE

Consent to Psychotropic Medication Treatment for my child:
Understanding of Clinical Treatment Guidelines and
Collaboration between Medical Psychologist and Physician

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

My child is being seen by [ ] David Jackson, PhD, MP, [ ] Mayling Walker, PhD, MP, [ ] Michelle Niemeier, PhD, MP, a Medical Psychologist for the purposes of medical/ psychopharmacological intervention (meaning psychological treatment with medication, if indicated). My signature reflects my expressed and specific desire to have the Medical Psychologist manage any psychotropic medications he/she has prescribed for my child. The Medical Psychologist will work in collaboration and in concurrence with my child's referring or attending physician.

I understand that my child will undergo an evaluation by a Medical Psychologist. If my child meets classification criteria, he or she will be diagnosed accordingly based on the current guidelines of Diagnostic and Statistical Manual of Mental Disorder, 5th Edition (DSM-5). This process typically considers information provided to the doctor via a diagnostic interview, behavioral observations, and data obtained from laboratory and psychological instruments. I am aware that a diagnosis may be updated or changed, consistent with standards of care and any pattern of emerging and clinically valid evidence.

The medical psychologist's diagnostic impressions and treatment recommendations will be communicated with me. If pharmacological interventions are recommended as part of the treatment plan, a decision to medicate my child will be made collaboratively between parents/caregivers and the medical psychologist in an effort to improve my child's functioning. I have been informed that medications can reduce or alleviate symptoms, but do not cure illnesses. The goal of treatment is to maximize benefits and minimize risks.

DO NOT WRITE OU BOX

I understand that the medical psychologist will carefully review the medication(s) with me and provide information about potential side effects. I understand that in certain situations, taking medication may cause physical and emotional discomfort to my child, could worsen my child's condition, or in rare instances, may even cause more serious complications such as potential misuse, abuse, or addiction and dependency; permanent damage; or death. I am aware that many prescribed medications do not have FDA-approval specifically for use in children.

I agree to work closely with my prescribing doctor and understand it is my responsibility to discuss the effects the medication is having on my child so that he/she can continue to assist me in ensuring the health and progress of my child's development. I agree to make sure that my child has taken his/her prescribed medication(s) at each follow-up appointment with the medical psychologist so that vital signs can be monitored.

I agree to notify my doctor in advance before personally making any changes to the agreed-upon treatment plan, including adjusting dosages and/or discontinuation of use, so that any changes will be made with my doctor's approval and supervision. This is done to ensure my child's safety. I understand that drug discontinuation can pose serious problems.

I indicate, by my signature below, that I have received this necessary information in order to make an informed decision on behalf of my child. I understand I may withdraw my consent at any time.

_____

Parent/Guardian Signature | Date

AQ-10 (Adolescent Version)

Name: _____

Birthdate: _____

A quick checklist for caregivers to complete about an adolescent aged 12–15 years.

Please check only one box per question:	Definitely Agree	Slightly Agree	Slightly Disagree	Definitely Disagree
1. S/he notices patterns in things all the time				
2. S/he usually concentrates more on the whole picture, rather than the small details				
3. In a social group, s/he can easily keep track of several different people's conversations				
4. If there is an interruption, s/he can switch back to what s/he was doing very quickly				
5. S/he frequently finds that s/he doesn't know how to keep a conversation going				
6. S/he is good at social chit-chat				
7. When s/he was younger, s/he used to enjoy playing games involving pretending with other children				
8. S/he finds it difficult to imagine what it would be like to be someone else				
9. S/he finds social situations easy				
10. S/he finds it hard to make new friends				

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NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

American Academy of Pediatrics

NICHQ

McNeil

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved, complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47 _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil

PLACE PATIENT'S LABEL HERE

NEW PATIENT CHILD/ADOLESCENT REGISTRATION

CHILD'S Name: _____ Nickname: _____
DATE OF BIRTH: _____ AGE: _____ SSN: _____
GENDER: MALE/FEMALE
ADOPTED? YES/NO IF YES, AT WHAT AGE: _____ IS ADOPTION KNOWN? YES NO
HANDEDNESS: RIGHT LEFT BOTH

FATHER: _____ AGE: _____ DOB: _____
SSN: _____
ADDRESS: _____ CITY/ZIP: _____
HOME PHONE: _____ EMAIL: _____
PHONE (CELL): _____
EMPLOYER: _____
WORK PHONE: _____ CAN A MESSAGE BE LEFT AT WORK? YES NO

MOTHER: _____ AGE: _____ DOB: _____
SSN: _____
ADDRESS: _____ CITY/ZIP: _____
HOME PHONE: _____ EMAIL: _____
PHONE (CELL): _____
EMPLOYER: _____
WORK PHONE: _____ CAN A MESSAGE BE LEFT AT WORK? YES NO

DO NOT WRITE OUTSIDE BOX

CHILD'S PRIMARY CARE PHYSICIAN: _____
NAME OF CLINIC: _____
PHONE #: (___) _____ FAX #: (___) _____
ADDRESS: _____

PERSON TO CONTACT IN CASE OF EMERGENCY:
NAME: _____ RELATIONSHIP: _____
HOME PHONE: _____ CELL PHONE: _____

_____ _____
PARENT/GUARDIAN'S SIGNATURE DATE

PLACE PATIENT'S LABEL HERE

CHILD/ADOLESCENT QUESTIONNAIRE-PLEASE COMPLETE ALL SECTIONS

PATIENT NAME: _____ DATE OF BIRTH: _____

Briefly describe the problems your child is having and when they began:

_____

_____

_____

_____

_____

MENTAL HEALTH HISTORY

Has your child ever been abused (emotionally, physically, or sexually)? YES NO

Explain: _____

_____

_____

Has your child ever experienced any other emotional or physical trauma? YES NO

Explain: _____

_____

_____

Has your child ever...

a) been in counseling? YES NO
b) been hospitalized for emotional or alcohol/drug problems YES NO
c) been professionally evaluated YES NO
d) received special education services YES NO

If yes to any of the above, please provide dates, names of agencies, reason for service, and outcome:

_____

_____

_____

Please list any family history of mental health/substance abuse problems:

_____

_____

***********************Please bring your child's medications to the first session***********************

Please list any medications your child has taken in the past for emotional/behavioral problems: NONE

LIST: _____

_____

_____

DO NOT WRITE OUTSIDE BOX

PLACE PATIENT'S LABEL HERE

GENERAL MEDICAL HISTORY

This medical form should be completed by the parent or guardian of the child being evaluated or treated at Children's Hospital Department of Psychology or Rapid Treatment Program.

Please complete the form, sign and date it.

	YES	NO
1. Are your child's immunizations up to date?	____	____
2. Has your child ever passed out during or after exercise?	____	____
3. Has your child ever had any dizziness during or after exercise?	____	____
4. Has your child ever had pain during or after exercise?	____	____
5. Does your child get tired more quickly than friends doing exercise?	____	____
6. Had your child ever had racing or skipping heart beats?	____	____
7. Have you ever been told your child has high blood pressure?	____	____
8. Have you ever been told your child has a heart murmur?	____	____
9. Has any family member or relative died of heart problems or of sudden? Death before the age of 50?	____	____
10. Has any family member or your child been diagnosed with:		
a. Enlarged heart?	____	____
b. Hypertrophic cardiomyopathy?	____	____
c. Long QT Syndrome?	____	____
d. Marfan's Syndrome?	____	____
e. Brugada Syndrome?	____	____
f. Lev Lenegre's Syndrome?	____	____
g. Wolfe Parkinson White Syndrome?	____	____
h. Idiopathic Ventricular Fibrillation?	____	____
i. Catecholaminergic Polymorphic VT?	____	____
j. Cardiac Conduction Defect?	____	____
k. Polymorphic Ventricular Tachycardia?	____	____
l. Any genetic disorder?	____	____
11. Is your child missing any paired organs?	____	____
12. Does your child have frequent headaches?	____	____
13. Has your child ever had any concussion or head injury?	____	____
14. Has your child ever had any seizures?	____	____
15. Is your child currently taking any prescription medications? List them: _____	____	____
16. Is your child taking any over the counter medications? List them: _____	____	____
17. Does your child have any chronic or current medical conditions? List them: _____	____	____

18. Please list all allergies your child has to medications or other substances such as food allergies:

_____

I have reviewed my family's history and child's history and attest the medical history form is accurate.

_____ _____

Parent Signature Date

DO NOT WRITE OUTSIDE BOX

PLACE PATIENT'S LABEL HERE

FAMILY STATUS

Are the child's biological parents currently married? ( ) YES ( ) NO

If no, custody is with ( ) Mother primary ( ) Father primary ( ) Joint ( ) Other _____

**********************PLEASE PRODUCE DOCUMENTATION OF CUSTODY ORDERS*********************

Please describe living arrangements, visitations, etc.:

_____

_____

_____

List all people currently living in your home, and the relationship of each to your child:

_____

_____

_____

_____

Are there any traditions/events that are important or traumatic for your child?

_____

_____

Is there any additional information you feel would be helpful to the treatment of your child?

_____

_____

DO NOT WRITE OUTSIDE BOX

DEVELOPMENTAL HISTORY

Pregnancy

Was your child's pregnancy planned? ( ) Yes ( ) No

Please check any of the following experienced during mother's pregnancy with the child being evaluated:

_____ Excessive vomiting

_____ Smoking _____ Drug use

_____ Excessive spotting/blood loss

_____ Alcohol consumption

_____ Illness

_____ Threatened miscarriage

_____ Prescription medications

_____ X-rays

_____ Toxemia/Infection

_____ Hospitalization (other than delivery)

Were they any problems with the pregnancy?_____

_____

_____

PLACE PATIENT'S LABEL HERE

Pregnancy: ( ) Full Term ( ) Premature by: _____ weeks ( ) Late by: _____ weeks
Were there any problems with the delivery? ( ) Yes ( ) No If Yes, please describe the problems:

_____

_____

Early Childhood

Milestones-Please report the ages or if you cannot remember check one of the following:

Smiled	_____ Early	_____ Average	_____ Late
Crawled	_____ Early	_____ Average	_____ Late
Sat up on own	_____ Early	_____ Average	_____ Late
Stood unassisted	_____ Early	_____ Average	_____ Late
Walked unassisted	_____ Early	_____ Average	_____ Late
Spoke first words	_____ Early	_____ Average	_____ Late
Said sentences	_____ Early	_____ Average	_____ Late
Toilet Trained	_____ Early	_____ Average	_____ Late
Ran	_____ Early	_____ Average	_____ Late
Fed Self	_____ Early	_____ Average	_____ Late
Dressed Self	_____ Early	_____ Average	_____ Late

Were there any illnesses, behavioral difficulties, or discipline problems during early childhood? ( ) Yes ( ) No
Please describe if yes _____

_____

Did your child have temper tantrums? ( ) Yes ( ) No Describe if yes: _____

_____

_____

What discipline techniques are used? _____

Do you, as parents, use consistent disciplining? ( ) Yes ( ) No

EDUCATIONAL HISTORY

Current School: _____ Grade: _____

How many different schools has your child attended? _____

Has your child repeated or skipped a grade? ( ) Yes ( ) No Describe if yes: _____

_____

What is her/his attendance like at school? ( ) Poor ( ) Good If attendance is poor, why? _____

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PLACE PATIENT'S LABEL HERE

Has she/he had any discipline problems at school and/or been suspended or expelled? ( ) Yes ( ) No
Explain: _____

_____

What are her/his grades like? _____

Have they changed recently? ( ) Yes ( ) No Explain: _____

_____

With which subject(s) does she/he have trouble? _____

Has she/he been diagnosed with a learning disability or attend special education services? ( ) Yes ( ) No

Briefly describe any special services being provided for your child in school/preschool: _____

_____

_____

****************Please bring any previous school assessments to your first appointment****************

SOCIAL HISTORY

Does your child make friends easily? ( ) Yes ( ) No
Does your child have difficulty keeping friends? ( ) Yes ( ) No
Briefly describe any peer interaction problems experienced by your child: _____

_____

_____

Have there been any recent losses, changes or transitions in your child's life? _____

_____

_____

Does the family have any spiritual, cultural, or religious beliefs that influence the child? _____

_____

_____

Please describe your child's strengths, weaknesses, accomplishments, talents, and areas of interest:

_____

_____

I have read each question and completed the form to the best of my ability.

_____ _____

Parent Signature Date Attending Doctor Date/Time

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