Tullahoma Pediatrics, PLLC/ Manchester Pediatrics

PATIENT INFORMATION SHEET

Patient Full Legal Name: _____ Nickname: _____ Birth date: _____

Patient's Address: _____ City: _____ State: _____ Zip: _____

Patient Home Phone: _____ Patient SS#: _____ Sex: Male _____ Female _____

Emergency Contact (not parents/guardian): _____ Relationship to patient: _____ Phone: _____

Ethnicity (Please circle): American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander Black/African American White Hispanic Other Race

Race (Please circle): Hispanic or Latino Not Hispanic or Latino Decline to Answer

Preferred Language: _____ Preferred Method of Contact: _____

Insurance #1

Name of Insurance: _____

Person who is insured: _____

Relationship to Patient: _____

DOB of Insured: _____

SS# of Insured: _____

Insurance #2

Name of Insurance: _____

Person who is insured: _____

Relationship to Patient: _____

DOB of Insured: _____

SS# of Insured: _____

I HAVE NO OTHER INSURANCE THAN THOSE LISTED ABOVE [ ] Initials [ ] Date

Mother

Name: _____

Address: _____

City: _____ State: ___ Zip: _____

Phone #: _____

Date of Birth: _____

Social Security #: _____

Employer: _____

Employer Phone: _____

Email: _____

Father

Name: _____

Address: _____

City: _____ State: ___ Zip: _____

Phone #: _____

Date of Birth: _____

Social Security #: _____

Employer: _____

Employer Phone: _____

Email: _____

Legal Guardian/Step-Parent

Name: _____

Address: _____

City: _____ State: ___ Zip: _____

Phone #: _____

Date of Birth: _____

Social Security #: _____

Employer: _____

Employer Phone: _____

Email: _____

PIN Numbers

As a security measure and in compliance with the federal HIPPA regulations, we will assign your child a four-digit PIN number. Please keep this number in a secure place because each time your child comes to our office we will ask you for the PIN number and your child's insurance card. If you are unable to bring your child in for his/her appointment, and you ask someone else to accompany your child, you will need to give that person your child's PIN number and insurance card. A PIN number may be changed at any time in person by the parent or legal guardian with proof of identity and authorization.

I understand I am giving permission for another person to make medical decisions and obtain medical information for my child when I give them my child's PIN number. [ ] **(Initials)**

I understand by providing my child's PIN number I will be able to obtain medical information over the phone and in the office. [ ] **(Initials)**

RELEASE AND ASSIGNMENT

I authorize release of any medical information or other information necessary to process my insurance claims. I assign and request payment directly to my physicians. I understand that some services may not be covered by insurance. I accept full financial responsibility and agree to pay the full amount due or the remainder not paid by insurance. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I understand that I am responsible to provide a current copy of my insurance card each time my child is seen to assure correct billing. I understand that if I don't provide the correct insurance I am responsible for the full amount due. I understand that I am responsible for providing this office with any updated information. I understand that I am required to complete and sign a patient information sheet yearly.

Signature: _____ Date: _____

Tullahoma Pediatrics, PLLC/ Manchester Pediatrics

RESPONSIBLE PARTY STATEMENT

Definition: The responsible Party is the person(s) who presents the patient to Tullahoma Pediatrics, PLLC/ Manchester Pediatrics for treatment and completes this form. The Responsible Party authorizes Tullahoma Pediatrics, PLLC/Manchester Pediatrics to furnish information to insurance carriers concerning patient's illness and treatments.

RESPONSIBILITIES:

ALL CHARGES are due at the time services are rendered unless patient is a member of an insurance plan with which Tullahoma Pediatrics, PLLC/Manchester Pediatrics participates. Tullahoma Pediatrics, PLLC/Manchester Pediatrics only allows contractual adjustments for plans with which our physician currently have a contract.

If patient is covered by a plan with which Tullahoma Pediatrics, PLLC/Manchester Pediatrics participates, the following will apply:

COPAYS are due at the time of service unless the co pay is a percentage of allowable charges, in this case, co pay will be due immediately after insurance has processed claim with a dollar amount as co pay.

ALL CHARGES deemed patient responsibility after insurance has processed the claim are due immediately. This includes co pays, deductibles, co insurance and non-covered services.

Responsible Party is responsible for all charges whether or not covered by insurance.

A valid patient's insurance card must be presented at each and every visit.

Tullahoma Pediatrics, PLLC/Manchester Pediatrics must be notified immediately of coverage changes. Failure to provide us with timely insurance information or change in coverage could result in the responsible party being held liable for the total charges.

Any services filed with your insurance that are not responded to any time after 90 days from the date of service may be transferred to patient balance and will become the responsibility of the family.

RIGHTS:

Tullahoma Pediatrics, PLLC/Manchester Pediatrics will file claims promptly for patients who participate with contracted insurance plans.

To receive a copy of charge/payment history for account as requested.

A copy of this statement may be given upon request to the person(s) who have signed or who have been authorized by the responsible party to receive a copy.

This statement will be valid unless rescinded in writing at a later date.

I have received a copy of Tullahoma Pediatrics, PLLC/ Manchester Pediatrics Financial Policy which further outlines my rights and responsibilities.

Initials

By my signature I understand and agree to the conditions outlines in this statement and those in the Financial Policy.

Printed Name Date

Signature Witnessed by Staff Signature

Tullahoma Pediatrics, PLLC/ Manchester Pediatrics

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about patients to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of our health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with other service providers (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for the purpose of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI, you may not revoke actions that have already been taken which rely on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.
You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

I have reviewed the Notice of Privacy Practices and I have obtained a copy of the compliance assurance notification. At this time I have no questions for the HIPAA Compliance Officer.

Print Patient's Name	Signature of Parent or Guardian	Date

Witness Signature	Date

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patient and Family Members:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, manager, and physicians continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problems of improper disclosure of PHI. As part of this plan we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect. Our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients and family members.

Notice of Privacy Practices

Health Care Operations: We may use and disclose Protected Health Information for office operations. For example, we may use Protected Health Information in connection with: conducting quality assessment and improvement activities: complying with medical reviews, audits and state agencies as required by law, business management and general administrative activities, including customer service, claims inquiry, and the resolution of internal grievances.

Business Associates: We may disclose Protected Health Information to assist in certain health care operations, such as the operation and management of Electronic Medical Record Systems and Information Technologists. However, such disclosures will not be made unless the Business Associate contractually agrees to appropriately safeguard your Protected Health Information. We will only disclose the minimum Protected Health Information necessary to operations.

Appointment Reminders & Important Notices: We may use Protected Health Information to contact you as a reminder that you have an appointment for treatment or to follow-up regarding medical care. We may use the emergency contact information you give us to contact you if the telephone and address we have on record is no longer correct.

Family Members & Friends Involved in Your Care: We may share Protected Health Information with your family member, other relative, close personal friend, or other person that you identify and authorize by your disclosure of your child's PIN number or in writing. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure to another person is in your best interest. In such circumstances, we will only disclose the Protected Health Information that is directly relevant to the person's involvement with your child's health care or payment for health care.

Research: We may use the information you provide for research purposes when we have reviewed and approved the research proposal. Medical record information that identifies you or your child will only be used when given permission for us to do so. Additionally, when given permission, we may contact you regarding research purposes.

Treatment Alternatives: We may use the information you provide to tell you about or recommend possible treatment options or other health related benefits and services that may be of interest to you.

Why do I have to sign a consent form?

When you sign the Tullahoma Pediatrics Patient Consent Form, you are giving us permission to use and disclose Protected Health Information for treatment, payment, and health care operations as described above. The permission does not include psychotherapy notes, psychosocial information, alcoholism and drug abuse treatment records, marketing, and sale of protected health information and other privileged categories of information, all of which require a separate permission. You will need to sign a separate consent form to have Protected Health Information given out for any reason other than treatment, payment or health care operations or as required or permitted by law.

When is your consent not required to disclose protected health information?

Required by law or public health agency: We may disclose Protected Health Information when required to do so by federal, state or local laws. We may disclose Protected Health Information for the following reasons.

- In an emergency
- When communication or language is very limited
- When required by law
- When there are risks to public health
- To report reactions to medications and malfunction of durable medical equipment
- To conduct health oversight activities such as investigation, inspection, audits, surveys and licensing
- To report suspected child abuse or neglect
- To certain government agencies who monitor activity such as federal officials for intelligence, counterintelligence, and national security
- In connection with court or government cases
- For law enforcement purposes
- To coroners and funeral directors and for organ donation
- To report births

- If health or safety is seriously threatened
- In connection with programs providing benefits for work-related injuries or illness.
- To provide immunization records to the Department of Health, physicians, health insurance company, state and federal agencies and schools upon the entities request.

Other uses and disclosures require your Authorization

Uses and disclosures of your Protected Health Information that are not described above will be made only with your written authorization. Your written authorization is required by law for us to disclose psychotherapy notes, psychosocial information, behavioral health visits, behavioral health diagnostic testing, alcoholism and drug abuse treatment records, marketing, and sale of Protected Health Information. Please be aware that once we have disclosed your Protected Health Information to a third party entity at your request, that entity may not be required to follow the same protection and privacy laws that we are required to follow so your information may no longer be kept private. There may be fees associated with the costs of providing records to you, or to a third party that you designate.

Can I change my mind and withdraw permission to disclose PHI?

If you provide us with an authorization to release your Protected Health Information, you may revoke it at any time, in writing, and this revocation will be effective for future uses and disclosures of Protected Health Information. However, the revocation will not be effective for information that we have already used or disclosed in reliance on previous authorization.

What happens if my PHI is disclosed without my authorization to someone not listed above?

You have the right to be notified if your Protected Health Information is breached. We have put safeguards in place to keep Protected Health Information secure. However, there is always a possibility that a breach in Protected Health Information could occur. We will notify you as required by law of any breach involving your child's (your) unsecured Protected Health Information. We will promptly investigate the occurrence, assess potential damages, and do our best to prevent the breach from reoccurring.

Your Privacy Rights

In accordance with federal regulations and Tullahoma Pediatrics policies and procedures, you have the following rights with respect to your Protected Health Information.

You have the right to request a restriction on certain uses and disclosures of your child's (your) health information. We will make every effort to honor your request to restrict the disclosure of PHI. In some situations, we may be required by law to share the health information. As an example, tuberculosis (TB) results are required by law to be reported to the Health Department. Although we will consider all restriction requests carefully, we are not required to agree to any requested restriction.

You have the right to request specific Protected Health Information from being disclosed to your insurance provider. You may request a restriction of PHI if services are paid for in full, out-of-pocket at the time of service, providing that acceptance of the payment for service is allowed by law. At this time, we are not allowed to accept payments out-of-pocket for covered services from TennCare members.

You have the right to request confidential communications. If our disclosure of all or part of your Protected Health Information could endanger you, you have the right to request that we communicate with you about your Protected Health Information in a different way or at a different location. For example, you may ask that we only contact you at a work address. It is your responsibility to make sure that we have your correct address and contact information. These requests must be made in writing to the Tullahoma Pediatrics Privacy Officer at the address listed below.

You have the right to review and ask for a copy of your child's (your) health information. This means that you may review and get a copy of your PHI that is contained in a designated record set for as long as we keep the PHI. A designated record set contains medical and billing records and any other records that Tullahoma Pediatrics, PLLC uses to make decisions about your child's (your) health care. You may not read or be given a copy of psychotherapy notes; information collected for use in a civil, criminal, or administrative action, or court case; and certain PHI that is protected by law. In some situations, you may have the right to have this decision reviewed. Please contact the Privacy Officer listed below if you have questions about access to your child's (your) medical record. If needed and at your

request, we may provide an electronic copy of your child's (your) record if we are able to do so. A fee will be charged for requesting a copy of your health or medical records.

Request to correct/amend information in your or your child's health record. If you believe that your Protected Health Information is incorrect or incomplete, you have the right to request that we amend it. To request an amendment, submit your request in writing to the Tullahoma Pediatrics Privacy Officer listed below. Specify your requested amendment and the reason(s) that you believe the amendment is necessary.

We may deny your request if the reason (s) listed do not support your request. We may also deny your request if you ask us to amend information that was not created by us, is not part of the information that you would be permitted to inspect or copy, or is accurate and complete. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement or accurate summary thereof.

You have the right to an accounting of disclosures of your Protected Health Information. You have the right to receive a listing of disclosures of the health information for purposes outside of treatment, payment, office operations, releases to you, incident to an otherwise permitted use or disclosure, or pursuant to an authorization by you or your authorized representative. To request an accounting, submit your request in writing to the Tullahoma Pediatrics Privacy Officer listed below.

You have the right to receive a paper copy of this Notice of Privacy Practices.

What if I have a question or complaint?

If you have questions regarding your privacy rights please call the Tullahoma Pediatrics, PLLC/Manchester Pediatrics Privacy Officer. If you believe your privacy rights have been violated, you may file a complaint by contacting the Tullahoma Pediatrics, PLLC/ Manchester Pediatrics Privacy Officer or the Regional office of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Tullahoma Pediatrics, PLLC
Manchester Pediatrics
Privacy Officer
P. O. Box 1327
1330 Cedar Lane, Bldg B, Ste 900
Tullahoma, TN 37388
Tel: (931) 455-2674
Fax: (931) 455-7594

Office of Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Ste 16T70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Tel: (800) 368-1017
TDD: (800) 537-7697
Fax: (404) 562-7881

TULLAHOMA PEDIATRICS, PLLC/ MANCHESTER PEDIATRICS

FINANCIAL POLICY

Welcome to Tullahoma Pediatrics, PLLC/Manchester Pediatrics! We're glad you've chosen us as your child's pediatricians and we strive to give your child the best in medical care. We understand that in addition to needing to feel comfortable with your child's physician, many parents have concerns about the financial policies of the practice. This information is designated to answer frequently asked questions.

CONTRACTED INSURANCE FILING:

We do take most private insurances. If you do not see your insurance company listed please call our billing department to verify coverage. We currently have contracts, and are considered "in network" with the following insurance companies/plans:

Blue Cross Blue Shield	Principal	Great West	Cigna
Tricare Standard	FMH Benefit Services	Aerospace	Aetna
United Health Care	Benefit Planners	GEHA	

We do NOT participate in PHP, Amerigroup or Tricare Prime.

Tullahoma Pediatrics/Manchester Pediatrics policies regarding our participation with the following contracted plans are as follows:

United HealthCare Community Care Plan
TennCare Select
BlueCare

1. Tullahoma Pediatrics/Manchester Pediatrics has agreed to file insurance claims for patients who participate in these plans. In order to do this as accurately as possible, we MUST see your child's insurance card at each visit; and if you participate with a managed care program, one of our physicians' names must appear on the card.
2. IF YOU DO NOT HAVE YOUR CHILD'S INSURANCE CARD AT EACH VISIT OR ANOTHER PHYSICIAN'S NAME APPEARS ON THE CARD, YOU MAY BE ASKED TO SIGN A WAIVER AND LEAVE A PAYMENT AT THE TIME OF VISIT.
3. We will, in some cases, accept a paper copy of online eligibility at check-in, as long as it includes patient's name, proof of eligibility for medical services on the date of service, and online address of contracted insurer.
4. We collect all co-payments at the time services are rendered and file insurance on a daily basis.
5. Any services that are deemed to be the family's responsibility (additional co-pays, co-insurance, deductible, etc) or that are considered non-covered by your insurance will be put to patient balance and are due immediately.
6. Any service that we file with your insurance that is not responded to after 90 days from the date of service may be transferred to patient balance. This balance will remain the responsibility of the family until payment is received or written correspondence is received by the insurance company verifying that payment is forthcoming from them.
7. A monthly statement will be sent to you detailing unpaid charges. If you have questions regarding items which have not been paid by your insurance, we ask that you contact your insurance company or employer as benefit packages vary by employer.

TULLAHOMA PEDIATRICS, PLLC/ MANCHESTER PEDIATRICS

FINANCIAL POLICY

NON-CONTRACTED INSURANCE OR SELF-PAYS:

If we do not participate with your insurance plan, we ask that you pay in full at the time services are rendered.

SEPARATED/DIVORCED FAMILIES:

1. For those families where parents are separated or divorced, the parent authorizing treatment and bringing the child to be seen is responsible to us for payment. All payments are due when services are rendered.
2. In case of contracted insurance only, co pay is due at the time services are rendered. Subsequently all charges deemed parent responsibility by the contracted insurer are due to Tullahoma Pediatrics/Manchester Pediatrics by the parent who authorized treatment.
3. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent. Tullahoma Pediatrics/Manchester Pediatrics will not act as a mediator in collecting our payments.
4. A copy of the bill with appropriate insurance coding will be given to the authorizing parent upon request.
5. If the account is not resolved in a timely manner, the authorizing parent's information may be submitted to our collection agency.
6. Non-Compliance with this policy may result in transfer of care to another practice.

PRACTICE CLOSED TO THE FOLLOWING PANELS:

Tullahoma / Manchester Pediatrics is closed to the following populations:

PHP Amerigroup TriCare Prime

*A patient is established only if they have been seen by one of our providers within the past 3 years.

Tullahoma Pediatrics, PLLC
Manchester Pediatrics
Mailing address: PO Box 1327
Tullahoma, TN 37388
Phone: 931-455-2674
Fax: 931-455-8983
www.tullahomapediatrics.com

Clifford A. Seyler, MD, FAAP
Jennifer Goodwin, FNPC
Kari Pitchko, CPNP
Marcia Cowan, CPNP
Carol Landerman, FNPC
Kara Hall, FNPC
Danielle Nicholls, CPNP

Records Release Authorization

Please release records on the following patient:

Patient's Name:_____ DOB:_____
(Please use a separate authorization for each child)

The charge to release records is a fee of $5.00 for 1-5 pages, or $10.00 for 6-10 pages, or $20.00 which shall include the first forty (40) pages of the medical record and twenty-five cents (.25c) per page for all pages thereafter, plus the actual cost of mailing. A summary report provided directly to another Pediatrician will not incur a charge.

Information must be complete	***Release records To X From_____**
Name:	Tullahoma Pediatrics, PLLC
Address:	PO Box 1327
City, State:	Tullahoma, TN 37388
Tel:	Telephone: (931) 455-2674
Fax:	Fax: (931) 455-8983

Please choose a reason for the records release:

X Changing Primary Care Provider
_____ Evaluation and management of behavioral or developmental health
_____ Applying for services, benefits, program
_____ Coordination of care or services
_____ Other please list: _____

I authorize the health care provider to release any and all information specified to the organization, agency, or individual named on this request as follows:

Medical Records (does not include Psychological records)

_____ Medical Record Summary (No Charge)
_____ Individual office visits (Usually extensive, see charges listed above)
_____ Well Child Exams & Immunization Record (No Charge)
_____ Labs/Xrays/Reports from referred health care providers
_____ Previous medical records
_____ Medical and Social history

Psychological Health Records

_____ Medical & social history
_____ Diagnostic testing results and Diagnoses
_____ Treatment Plan, Medication List, Progress Notes
_____ Mental health treatment records from other providers
_____ Substance Abuse
_____ AIDS/HIV records

Release of information is further restricted / released as noted below:

_____ Please include only the specified records from the dates of _____ through _____.
_____ Please allow *two-way communication* regarding the specified records, both written and verbal, between the two parties designated above.

This **authorization will automatically expire in 12 months** from the date I sign below unless an earlier date is specified. I understand that **I may revoke this authorization** at any time by notifying this office in writing. Tullahoma/Manchester Pediatrics **will not condition any provision of treatment on my signing** the authorization. Once the protected health information is disclosed, it **may no longer be protected**. **A copy of this authorization** may be utilized with the same effectiveness as an original. I am entitled to a copy of this authorization.

My signature below indicates that I am authorized to obtain/release records on the patient indicated. There is no court order denying guardianship, parental rights, or authorization to obtain/release these records. This authorization is given voluntarily without coercion.

Signature:_____ **Date:**_____

Name of individual signing the release: _____ Driver License/ID # of individual: _____

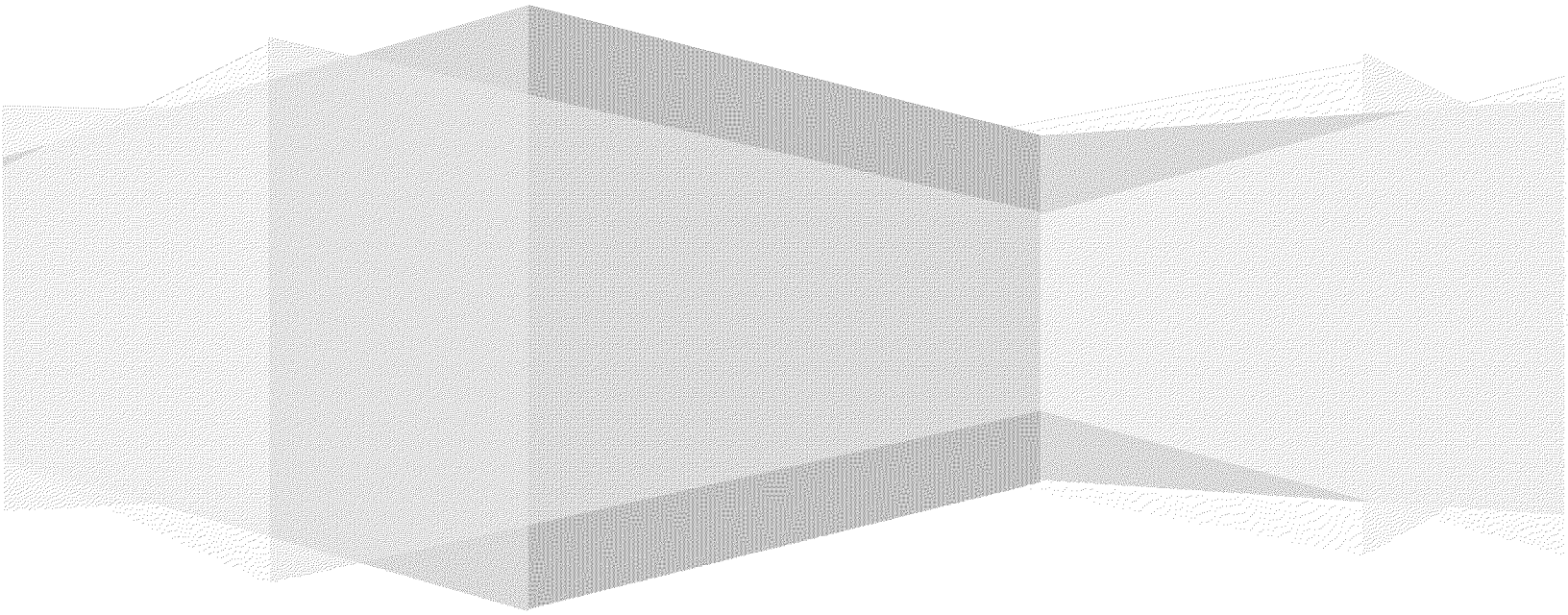
Individuals relationship to the patient: _____ Witness Signature: _____ Amount charged $ _____

Tullahoma/Manchester/Royal Pediatrics P.L.L.C.

NAME: _____
DATE GIVEN TO PARENT: _____
DATE RETURNED: _____
APPOINTMENT DATE: _____
Contact #: _____

CHILDHOOD MEDICAL AND SOCIAL HISTORY

DR. CLIFFORD SEYLER



Child's Name: _____ **Date of Birth**:_____**Age**:_____**Sex**: ____
Address: _____

_____

Phone:_____**Phone**: _____

Child resides with: ☐ biological mother ☐ biological father ☐ step mother ☐ step father ☐ foster parent
(check all that apply) ☐ adoptive mother ☐ adoptive father grandparent(s) circle- parent of father or mother
☐ other: _____

Name of current guardian: _____**Phone**: _____

If adopted, Age at the time of placement with adoptive parents: _____Age at the time of adoption: _____
Complete as much of the form as possible, anything you do not know please mark UNKOWN

Mother's Name: _____**Phone**: _____

Father's Name: _____**Phone**: _____

Parents: ☐ never married ☐ married ☐ separated ☐ divorced Age of child at sep/divorce: _____

Please list everyone who resides in the home: _____

_____

How many bedrooms? _____ Do you rent or own? _____

School: _____ Grade: _____
Special Placement (if any): _____

Referred by: _____Phone : _____
Address: _____

Briefly state current problems that influenced desire to seek a behavioral health consultation:

_____

_____

_____

_____

_____

_____

Changes or recent stress: (ex: move to a new home/school, divorce, birth of sibling, domestic violence, bullying at school)_____

_____

Pregnancy
Were there any known complications during pregnancy?

Excessive vomiting _____ Excessive blood loss _____ Toxemia ____ High Blood Pressure _____ STD'S _____
X-rays during pregnancy _____ Exposure to TB _____ Flu-like Symptoms/fever _____ Anemia _____ Diabetes ____
Rh Negative _____ Exposure to Lead or Chemicals _____ Hepatitis (A, B or C)_____ Kidney infections _____

	YES	NO	
Smoked during pregnancy	☐	☐	Per day?_____
Caffeine	☐	☐	Amount per day? _____
Consumed alcohol during pregnancy	☐	☐	Per day? _____
Street drugs used (Marijuana, hydrocodone, cocaine, meth)	☐	☐	Please specify:_____

Prenatal Care began: ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester or ☐ NO PRENATAL CARE
Prenatal Care Provider: _____
Duration of pregnancy: _____weeks Number of years between this pregnancy and previous pregnancy: _____

Delivery

Labor: ☐ Spontaneous ☐ Induced Hours of Duration _____
Multiple Births ☐ Yes ☐ No If yes, how many children: _____
Delivery: ☐ Normal ☐ Breech ☐ Caesarean

Were there any complications such as hemorrhage, cord around neck or infant injured? Yes ☐ No ☐
Explain: _____
_____

Birth Weight: _____ Length: _____ How long was child hospitalized after birth? _____
Did child leave hospital on the same day as parent? _____

Did your child:	YES	NO	EXPLAIN
Require Oxygen immediately after birth?			
Have Jaundice?			
Require transfer to Vanderbilt/Erlanger?			
Have seizures?			
Have a heart murmur?			
Turn blue?			
Require antibiotics?			
Have difficulty with feeding?			

Early Childhood

During the first three years of life, describe how your child…..

Enjoy being cuddled _____
Calmed when held or stroked _____
Comforted easily or not_____
Slept _____
Nursed/fed _____
Banged head (if at all) _____
Explored _____
Was Active _____
Coped with Change _____
Was Outgoing or Withdrawn _____
Displayed Emotions _____
Lived by routines _____
Attended to task _____
Was sensitive to light/sound/texture _____

Did your child receive Speech, Occupational or Physical Therapy or TEIS services prior to the age of 3? ☐ YES ☐ NO

Developmental Milestones (Please indicate if child was normal, early or late in reaching that milestone)

DEVELOPMENTAL MILESTONE	EARLY	NORMAL	LATE	DEVELOPMENTAL MILESTONE	EARLY	NORMAL	LATE
Smiled				Rode tricycle			
Sat without support				Rode bicycle			
Crawled				Buttoned clothing			
Stood without support				Tied shoelaces			
Walked without help				Dressed independently			
Spoke first words				Named colors			
Said phrases				Named letters			
Said sentences				Began to read			
Bladder trained				Began to count			
Bowel trained							

Coordination (Please indicate how coordinated you child is at the following skills)

SKILL	POOR	AVERAGE	EXCELLENT
Catching			
Throwing			
Skipping			
Walking			
Running			
Writing			
Athletic Abilities			

Describe any skills that were rated as poor performance _____
_____
_____
_____

Medical History

Has your child had any childhood illnesses/diseases? Please indicate age:

_____Allergies _____Anemia _____Asthma _____Bladder/Kidney Infection _____ Chicken Pox
_____Colic ____Diabetes _____Digestions Problems _____ Ear Infections _____ Eczema _____ Encephalitis
_____ Fifth's Disease _____Hearing Problems ___ Hepatitis _____Impetigo _____Kawasaki Disease _____ Measles
_____Mumps _____ Pneumonia _____ Rheumatic Fever _____ Rotavirus _____ RSV _____ Scarlet Fever
_____Seizures with fever _____ Seizures without fever _____ Strep Throat _____Vision Problems _____Exposure to environmental toxins (ex. Lead, Mercury) _____Tics/non-purposeful movements _____ Other: _____

Has your child ever been hospitalized? Please indicate age and purpose _____
_____
_____
_____
_____
_____

Has your child ever had an operation? (ex. Circumcision, tubes in ears, cardiac, hernia, appendectomy, adenoids or tonsils removed) Please indicate age and purpose _____
_____

Has your child had accidents resulting in… please describe
Frequent ER visits _____
Broken Bones _____
Eye Injuries _____
Severe Lacerations _____
Burn_____
Stomach pumped _____ _____
Head Injuries /Concussions_____
Stitches _____
Lost teeth_____
Poisoning _____

Are your child's immunizations up-to-date? ☐ YES ☐ NO Please attach records to this history form

Are your child's dental appointments up-to-date? ☐ YES ☐ NO

Has your child had recent changes in appetite? ☐ YES ☐ NO Please describe_____

Sleeping Habits	YES	NO
Does child settle down to sleep well?	☐	☐
Does child sleep through the night?	☐	☐
Does child have nightmares/night terrors?	☐	☐
Does child sleep walk/sleep talk?	☐	☐
Is child a VERY restless sleeper?	☐	☐
Is child insecure (sleep with parents)?	☐	☐
Does child wet bed?	☐	☐

If bedtime and sleeping through the night are problems, give details of a typical night's routine: _____

_____

_____

If mornings are a problem, give details of a typical morning's routine: _____

_____

_____

Bladder and Bowel Habits

Was child easily potty-trained? ☐ YES ☐ NO

Does child wet in pants now? ☐ YES ☐ NO

If yes, please circle when: Day Night Both

how frequently: _____

Does child have bowel accidents now? ☐ YES ☐ NO

If yes, please circle when: Day Night Both

how frequently: _____

Does child have frequent Urinary Infections? ☐ YES ☐ NO

Does your child have frequent constipation? ☐ YES ☐ NO

Past medications for psychological/behavioral problems: Attach a separate sheet if necessary

Date	Prescription	Dose	Response	Physician

Please list any other providers who have treated or currently treating your child: Attach a separate sheet if necessary

Name	Phone Number	Purpose

School Environment

Compared to other children your child's age, how do you see your child's ability to learn? Please circle one

Below Average **Normal** **Above Average**

Friendships Please check the statements that describe your child

☐ Has many friends	☐ Desires friends	☐ Has friends inviting him/her to join them
☐ Has few friends	☐ Most friends are child's age	☐ Most friends are younger/older than child
☐ Prefers to play alone	☐ Does not care about friends	☐ Is shy or withdrawn with others his/her age
☐ Aggressive toward peers	☐ Argues with classmates	☐ Is ignored by classmates
☐ Child is "bossy"	☐ Child compromises well	☐ Behavior causes others to reject child

	YES	NO
Did your child have any behavior problems in daycare/preschool?	☐	☐
Did your child have any behavior problems in kindergarten?	☐	☐
Does your child currently have behavior problems in school?	☐	☐

Has your child repeated any grades? ☐ YES ☐ NO Which grades? _____

Has your child ever been tested for learning problems at school?	☐ YES	☐ NO
Does your child have an IEP (Individual Education Plan)?	☐ YES	☐ NO
Does your child have a tutor or teacher's aide?	☐ YES	☐ NO
Does your child receive Special Education Services or Resource Classes?	☐ YES	☐ NO
Does your child receive Speech, Occupational or Physical Therapy?	☐ YES	☐ NO

Please check yes or no	YES	NO
Child frequently has homework to do at night		
Arguments about homework are common		
Homework is often not completed		
Homework takes more than 2 hours per night		
Is there a regular time to do homework?		
Is there a regular place to do homework?		
Does your child arrive home with all the books and assignments needed?		

Are there problems that the teacher has made you aware of? _____

Are there any additional academic concerns you have? _____

Please provide a sample of your child's handwriting. Please have the child write the sentence below in pencil if possible.

The quick brown fox jumped over the lazy dogs.

FAMILY HISTORY

Biological Mother

Name:_____Age:____Date of Birth_____

Occupation: _____ Highest grade completed: _____

Are you disabled? ☐ YES ☐ NO

Learning/Attention/Behavior Problems at school? _____

_____

_____

Medical Problems? ☐ YES ☐ NO if yes, please explain_____

_____

_____

Prescriptions taken regularly: _____

Have you ever had an inpatient hospitalization? ☐YES ☐NO If yes, please explain_____

_____

Have you ever been in jail? ☐YES ☐NO If yes, please explain_____

_____

Biological Father

Name:_____Age:____Date of Birth_____

Occupation: _____ Highest grade completed: _____

Are you disabled? ☐ YES ☐ NO

Learning/Attention/Behavior Problems at school? _____

_____

_____

Medical Problems? ☐ YES ☐ NO if yes, please explain_____

_____

_____

Prescriptions taken regularly: _____

Have you ever had an inpatient hospitalization? ☐YES ☐NO If yes, please explain_____

_____

Have you ever been in jail? ☐YES ☐NO If yes, please explain_____

_____

Family Psychosocial and Mental Health History (Place a check mark if anyone had/has experienced the following issues)

Psychological/Mental Health	Present Family				Mother's Family				Father' s Family			
	Mom	Dad	Brothers	Sisters	Moms Mom	Moms Dad	Brother (uncles)	Sister (aunts)	Dads Mom	Dads Dad	Brother (uncles)	Sister (aunts)
Aggressive/oppositional or strong-willed behavior as a (c) child or (a) adult												
Hyperactivity, easy to anger, or lack of impulse control as a (c) child or (a) adult												
Attention Problems, difficult focusing on task or activities as a (c) child or (a) adult												
Didn't graduate from high school												
Special Education/learning problems												
Psychosis/Schizophrenia/Bi-Polar/Mood disorders												
Obsessive Compulsive Disorder (OCD)												
Depression for more than 2 weeks												
Anxiety or excessive nervousness												
Austism												
Aspergers												
Tic or Tourette's												
History of Seizures												
Withdrawn or Isolated, Difficulty with socialization												
Mental Retardation												
Alcohol Abuse												
Tobacco Use												
Substance Abuse (marijuana, Hydros, Cocaine, meth)												
Antisocial Behavior (theft, assaults, arrest, etc)												
Arrests/incarcerations												
Suicide/Suicide Attempts												
Trauma												
Physical Abuse (V) victim or (O)Offender												
Sexual Abuse (V) Victim or (O) Offender												

Social History

Does your child have more temper tantrums than average children his/her age? If so, describe what an outside observer might see and for how long these tantrums might last _____

_____

Is the relationship with parents typical of a child his/her age? ☐ Yes ☐ No If no, please explain _____

_____

Do parents/guardians in the home agree on discipline in the home? ☐ YES ☐ NO If no, please explain _____

_____

Please list forms of discipline used that work

Please list forms of discipline that you found do not work

Have you ever attended parenting classes or counseling? ☐ YES ☐ NO if yes, explain

Is the relationship with siblings typical of a child his/her age? ☐ YES ☐ NO If no, explain

Are you concerned about how your child treats the family pet (s)? ☐ YES ☐ NO If yes, explain

Has your child ever experienced a trauma, such as a fire, physical or sexual abuse? ☐ YES ☐ NO If yes, explain

All children exhibit some behaviors that are more intense than other children their age, please mark yes if you feel your child exhibits a behavior that is more extreme than children the same age.

Behavior	Yes	Behavior	YES
Careless mistakes		Blurts out answers	
Difficulty paying attention		Difficulty remaining seated	
Does not listen		Runs/climbs when should be seated	
Difficulty finishing task		Difficulty playing quietly	
Poor organizational skills		Always on the go	
Avoids task of long duration		Talks excessively	
Loses necessary items		Difficulty waiting his/her turn	
Easily distracted		Interrupts others	
Forgetful		Fidgets with hands/feet/squirms	
Argues with adults		Fearful, anxious or worried	
Loses temper		Afraid to try new things	
Actively defiant with adults		Feels worthless or inferior	
Deliberately annoys other people		Blames self for problems	
Blames others for mistakes		Lonely, unwanted	
Easily annoyed by others		Sad, unhappy or depressed	
Is angry or resentful		Self-conscious, easily embarrassed	
Spiteful			
Physically cruel towards others		Has considered/attempted suicide	
Bullies		Has hurt him/herself	
Starts physical fights		Withdrawn/Isolated	
Lies to get out of trouble		Refuses to be alone	
Truant		Has consumed alcohol	
Steals things		Has used illegal drugs	
Deliberately destroys others' property		Uses tobacco	
Used a weapon to harm others		Has shown increased interest in sex	
Physically cruel to animals		Touches self excessively for his/her age	
Has set fires to cause damage		Has become sexually active	
Has run away overnight		Unusually affectionate with strangers	
Broken into someone else's home or car		Unusual crying spells	
Stays out all night		Exhibits poor judgment	
Forces sexual activity		Doesn't appear to learn from experience	