DIRECTIONS TO OFFICE:

FROM THE SOUTH:


FROM THE NORTH:

TAKE THE TACONIC PARKWAY SOUTH TO THE UNDERHILL EXIT. MAKE A RIGHT – TURN ONTO UNDERHILL AVENUE. FOLLOW FOR APPROXIMATELY ¼ OF A MILE AND THEN MAKE A RIGHT ONTO ROUTE 129. FOLLOW ROUTE 129, AFTER ENTERING CROTON-ON-HUDSON, THERE WILL BE A FORK IN THE ROAD. STAY TO THE RIGHT - ONTO GRAND STREET. THE OFFICE WILL BE ON YOUR LEFT. PARKING IS IN BACK OF BUILDING.

FROM THE BEAR MOUNTAIN BRIDGE:

Dear Parent/Guardian:

Please answer the following questions as best as you can and bring this form in with you the day of your appointment. If you have any questions about a specific piece of information being asked, you can call before your appointment as the information will be covered during the appointment. Thank you.

******* PAST MEDICAL HISTORY QUESTIONNAIRE*******

Child’s weight at birth? ___lbs. ___oz.

Was your child born full term? ___ yes ___ no

If not, at what week gestation? ___ weeks, or how many ___ weeks/___ months early?

What type of delivery did you have?

___ Vaginal (normal/spontaneous ___ Pitocin induced)

___ Cesarean Section – if so this was due to: ___ repeat ___ fetal distress

___ Failure of labor to progress Other: ____________________________

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

What number pregnancy is this? ___ What number delivery? ___

Hospital child born at ____________________________

Were there any maternal medical problems during pregnancy? ___Yes ___No

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

___ Bleeding ___ Diabetes ___ Infection ___ Hypertension

Were any medications taken during pregnancy? ___Yes ___No

If yes, what medication and why? ____________________________

______________________________

Did you have a fetal sonogram? ___Yes ___No – If yes, how many? ___

Result of fetal sonogram? ___Normal ___ Abnormal

If abnormal please explain ________________________________
Was the infant's stay in the nursery: _____ Uneventful _____ Complicated?
Complicated by what: __________________________________________________________
Please list any/all operations, hospitalizations (including Emergency Room visits), and procedures your child has had:
<table>
<thead>
<tr>
<th>Where</th>
<th>When</th>
<th>Why</th>
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General Pediatric Care is provided by:
Name: ____________________________________________
Address: _________________________________________

Are your child’s immunizations up to date? _____ Yes _____ No

Last vision exam/screening (when) ______ Normal findings? _____ Yes _____ No
If "No", problem was __________________________________________________________

Frequent ear infections? _____ Yes _____ No

Last hearing test/screening (when) ______ Normal findings? _____ Yes
If "No", problem was __________________________________________________________

Is your child currently taking medications? _____ Yes _____ No
If so, please list medications and reason for taking them:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Does the child have known allergies to foods or medications? _____ Yes _____ No
If yes, please list:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Does your child have?
- Poor growth?  ___Yes  ___No
- Heart problems?  ___Yes  ___No
- Asthma or other respiratory problems?  ___Yes  ___No
- Stomach or bowel problems?  ___Yes  ___No
- Urine problems?  ___Yes  ___No
- Motor weakness or coordination problems?  ___Yes  ___No
- Headaches?  ___Yes  ___No
- Seizures?  ___Yes  ___No
- Anemia or other blood disease?  ___Yes  ___No

If you answered "Yes" to any questions above, or if your child has any other health care problem not listed please explain:


Developmental History: Please list age at which your child:

- Sat up  __________
- Said mama/dada  __________
- Began 2 word phrases  __________
- Speech understood by strangers  __________
- Walked alone  __________
- Single words:  __________
- Began few word phrases  __________

Please note where child attended/attends school:

- 3-year nursery  __________
- Kindergarten  __________
- 2nd:  __________
- 4th:  __________
- 6th:  __________
- 8th:  __________
- 4-year nursery  __________
- 1st grade:  __________
- 3rd:  __________
- 5th:  __________
- 7th:  __________
- Other:  __________

Are any of the following therapies being currently provided:

- Physical Therapy  ___
- Speech Therapy  ___
- Occupational  ___
- Resource Room  ___
- Counseling  ___
- Other:  __________

Has your child ever had any evaluations such as Audiology, Psychology, or Speech/Language? If you are planning to bring in any evaluations for the doctor to review, PLEASE MAKE A PHOTOCOPY THAT YOU WILL LEAVE IN THE OFFICE. Our staff is not available to make copies for you.
For all children (when applicable): Describe peer interactions:


Child usually goes to sleep at _____ P.M.
Child ____ does _____ does not sleep through the night
Child ____ gets up _____ is awakened at _____ A.M.

For children 4 years and older:

Would you say that your child displays a lack of attention such as often:

1. Fails to give close attention to detail or makes careless mistakes:
   ___Yes ___No
2. Has difficulty sustaining attention in tasks or play activities:
   ___Yes ___No
3. Does not seem to listen:
   ___Yes ___No
4. Has difficulty following through on instructions from others:
   ___Yes ___No
5. Has difficulty organizing tasks and activities:
   ___Yes ___No
6. Avoid tasks which require sustained mental effort:
   ___Yes ___No
7. Loses necessary items such as school books and materials:
   ___Yes ___No
8. Is easily distracted:
   ___Yes ___No
9. Is forgetful in daily activities:
   ___Yes ___No

Would you say that your child displays hyperactivity such as often:

10. Fidgets:
    ___Yes ___No
11. Has difficulty staying seated:
    ___Yes ___No
12. Runs about excessively & Inappropriately:
    ___Yes ___No
13. Has difficulty playing quietly:
    ___Yes ___No
14. "on the go" or "driven by a motor"
    ___Yes ___No
15. Talks excessively:
    ___Yes ___No
16. Blurs out answers before questions
    Completed:
    ___Yes ___No
17. Has difficulty awaited turn:
    ___Yes ___No
18. Interrupts or intrudes on others:
    ___Yes ___No

FAMILY COMPOSITION

Mother's age _____ highest grade completed: _____ Father's age _____ highest grade completed: _____

Please list all other brother and sisters of child:

Name_________________________ Age___________ ___male ___female
Name_________________________ Age___________ ___male ___female
Name_________________________ Age___________ ___male ___female
Name_________________________ Age___________ ___male ___female

Do any other members of the family have developmental disabilities? ___Yes ___No / If yes, please explain below:
Pediatric Symptom Checklist

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

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

Total score

Does your child have any emotional or behavioral problems for which she/he needs help? ( ) N ( ) Y
Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?

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