Integrative Developmental and Behavioral Pediatrics, LLC

PATIENT REGISTRATION

Patient Name_____DOB_____Gender (M/F/other)

Parent/Guardian #1_____DOB_____Gender (M/F/other)

Relationship to patient_____

Address_____Home phone_____

City/State/Zip_____Cell Phone_____

Employer/Occupation_____Work phone_____

Communication by email represents a potential risk to patient confidentiality. By furnishing my email, I consent to the use of email to communicate. Email:_____

Would you like to receive information by email about changes to our office schedule or location, community resources and general medical information from our practice? (1-4 emails per month). **Please circle one: yes / no / will decide later**

We sometimes host medical students or physicians who appreciate observing appointments to learn more about developmental and behavioral pediatrics. Would you feel comfortable with an observer during your appointment? You can always change your mind, even at the last minute. **Please circle one: yes / no / will decide later / please ask before each appointment**

Please indicate best way to contact you: **Please circle one: cell / home / email / other:_____**

Parent/Guardian #2_____DOB_____Gender (M/F/other)

Relationship to patient_____

Address_____Home phone_____

City/State/Zip_____Cell Phone_____

Employer/Occupation_____Work phone_____

Communication by email represents a potential risk to patient confidentiality. By furnishing my email, I consent to the use of email to communicate. Email:_____

Would you like to receive information about changes to our office schedule or location, community resources and general medical information from our practice via email? (1-4 emails per month). **Please circle one: yes / no / will decide later**

We sometimes host medical students or physicians who appreciate observing appointments to learn more about developmental and behavioral pediatrics. Would you feel comfortable with an observer during your appointment? You can always change your mind, even at the last minute. **Please circle one: yes / no / will decide later / please ask before each appointment**

Please indicate best way to contact you: **Please circle one: cell / home / email / other:_____**

***PLEASE COMPLETE "ADDITIONAL PARENTS / GUARDIANS FORM" IF YOU WOULD LIKE TO LIST MORE THAN TWO PARENTS/GUARDIANS**

PATIENT REGISTRATION, page 2

Parents are: (circle all that apply): Married / Living together / Separated / Divorced / Other

If parents are not married, who is the custodial parent?_____

Sibling Name_____DOB_____Gender (M/F/other)

Sibling Name_____DOB_____Gender (M/F/other)

Sibling Name_____DOB_____Gender (M/F/other)

Sibling Name_____DOB_____Gender (M/F/other)

Additional siblings_____

Emergency Contact Person_____

Emergency Contact primary phone #_____secondary phone #_____

Who may we thank for referring you to us?_____

Patient Signature (if 14 or older)_____Date_____

Parent/Guardian Signature_____Date_____

Printed name of Parent/Guardian_____

Integrative Developmental and Behavioral Pediatrics, LLC

ADDITIONAL PARENTS/GUARDIANS

Patient Name_____DOB_____Gender (M/F/other)

Parent/Guardian_____DOB_____Gender (M/F/other)

Relationship to patient_____

Address_____Home phone_____

City/State/Zip_____Cell Phone_____

Employer/Occupation_____Work phone_____

Communication by email represents a potential risk to patient confidentiality. By furnishing my email, I consent to the use of email to communicate. Email:_____

Would you like to receive information about changes to our office schedule or location, community resources and general medical information from our practice via email? (1-4 emails per month). **Please circle one: yes / no / will decide later**

We sometimes host medical students or physicians who appreciate observing appointments to learn more about developmental and behavioral pediatrics. Would you feel comfortable with an observer during your appointment? You can always change your mind, even at the last minute. **Please circle one: yes / no / will decide later / please ask before each appointment**

Please indicate best way to contact you: **Please circle one: cell / home / email / other:_____**

Parent/Guardian_____DOB_____Gender (M/F/other)

Relationship to patient_____

Address_____Home phone_____

City/State/Zip_____Cell Phone_____

Employer/Occupation_____Work phone_____

Communication by email represents a potential risk to patient confidentiality. By furnishing my email, I consent to the use of email to communicate. Email:_____

Would you like to receive information about changes to our office schedule or location, community resources and general medical information from our practice via email? (1-4 emails per month). **Please circle one: yes / no / will decide later**

We sometimes host medical students or physicians who appreciate observing appointments to learn more about developmental and behavioral pediatrics. Would you feel comfortable with an observer during your appointment? You can always change your mind, even at the last minute. **Please circle one: yes / no / will decide later / please ask before each appointment**

Please indicate best way to contact you: **Please circle one: cell / home / email / other:_____**

_____ _____

Patient Name Date of Birth

Integrative Developmental and Behavioral Pediatrics, LLC

PHARMACY AND INSURANCE INFORMATION

Insurance Company_____

Policy #_____

Group #_____

Insurance Co. Address_____

Insurance Phone #_____Insurance Fax #_____

Subscriber_____Subscriber's DOB_____

Relationship to Patient_____

Preferred Pharmacy

Name_____Phone #_____

Address_____Fax #_____

_____ _____

Patient Name Date of Birth

Integrative Developmental and Behavioral Pediatrics, LLC

Medical and Behavioral Care Provider Communication List

Communication between providers is essential to optimize care. Please provide contact information below about your child's care team to that we can communicate with them as needed. (Example: Naturopath, Acupuncturist, OT, SLP, PT, psychologist or other mental or behavioral health therapist**). In addition to the information below, we will need a signed "Release of Information" form to communicate with each provider.**

Primary Care Physician_____Phone No._____

Address_____Fax #_____

City/State/Zip_____Email_____

Name_____Phone No._____

Address_____Fax #_____

City/State/Zip_____Email_____

Name_____Phone No._____

Address_____Fax _____

City/State/Zip_____Email_____

Name_____Phone No._____

Address_____Fax _____

City/State/Zip_____Email_____

Name_____Phone No._____

Address_____Fax _____

City/State/Zip_____Email_____

Integrative Developmental & Behavioral Pediatrics, LLC

AUTHORIZATION FOR RELEASE OF INFORMATION

Integrative Developmental and Behavioral Pediatrics
5319 SW Westgate Dr. Ste #168, Portland, OR 97221
(503) 444-1745 email: admin@donnakirchoffmd.com

Patient _____ Birth Date_____

I hereby authorize Integrative Developmental and Behavioral Pediatrics to (initial those that apply):

(initial)_____ release information to the below-named person, facility or agency

(initial)_____ obtain information from the below-named person, facility or agency

Person/Facility/Agency:_____

Address:_____

City_____State_____Zip Code_____

Phone Number_____Fax Number_____

Email_____

Communication by email represents a potential risk to patient confidentiality. Do we have permission to communicate with this provider by email? **Please circle one:** Yes/No Initial_____

By initialing below, I authorize the release of the following information, including mental health information:

(initial)_____progress notes
(initial)_____evaluation reports
(initial)_____lab results
(initial)_____other (please specify)_____

By initialing and signing below, I specifically authorize release of the following:
(initial)_____mental health information
(initial)_____genetic testing
(initial)_____drug/alcohol diagnosis, treatment, and referral information
(initial)_____HIV/AIDS information

_____
Patient signature (required if 14 years or older) Date

_____
Parent/Guardian/Legal Representative Date

_____
Printed Name and Relationship to Patient

By initialing below, the purpose of information disclosure is **(please initial all that apply):**

(initial)_____ to facilitate treatment and continuity of care
(initial)_____ to facilitate billing and reimbursement
(initial)_____ other (specify)_____

This authorization shall be in force and effect until such time as it is revoked by the patient or patient's representative, or 6 months after discharge from treatment by Integrative Developmental and Behavioral Pediatrics, whichever is sooner.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Donna Kirchoff at 5319 SW Westgate Dr. Ste #258, Portland, OR 97221 or admin@donnakirchoffmd.com

I understand that a revocation is not effective to the extent that Integrative Developmental and Behavioral Pediatrics has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Integrative Developmental and Behavioral Pediatrics will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to **(please initial both):**

(initial)_____Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law, to the extent the state law provides greater access rights.)

(initial)_____Refuse to sign this authorization.

_____

Patient signature (required if 14 years or older) Date

_____

Parent/Guardian/Legal Representative Date

_____

Printed Name and Relationship to Patient

_____ _____

Patient Name Date of Birth

Integrative Developmental & Behavioral Pediatrics, LLC

GENERAL OPERATIONAL POLICIES AND PROCEDURES

Services Provided: We provide evaluation and ongoing care for children from birth to 10 years of age who experience developmental and behavioral challenges. When appropriate, we provide ongoing care for established patients older than 10 years of age.

Our Mission: Our goal (and passion!) is to optimize your child's behavior and development by using an integrative medical approach, which coordinates traditional (allopathic) care with holistic, complementary, and/or "alternative" medical treatments.

Hours: The office phone is answered 9am-5pm, Monday through Friday. Our physical presence in the office is variable week-to-week.

Location: 5319 SW Westgate Dr. Ste #168, Portland OR 97221 (just north of Hwy 26 off of Sylvan):

After hours/emergencies: If you have an urgent issue that cannot wait until normal office hours (9-5, Monday-Friday), you may call Dr. Kirchoff on her cell phone at 503-307-0634. If you are unable to reach Dr. Kirchoff by cell phone, you should contact your child's PCP and/or take your child to the emergency room of the nearest hospital.

Appointment Scheduling: Appointments may be requested by calling 503-444-1745 or by emailing admin@donnakirchoffmd.com.

Fees/payment: See financial policy for more details – payment is due at the time of service, and we are not contracted with any health insurance companies.

Confidentiality: It is sometimes in the best interest for an older child to have particular information remain private between them and their provider. If you have concerns about this, please let us know, so that we can come to an agreement about handling communication. Children 14 and older are required to sign for any release or communication of health care information. There are certain circumstances when information obtained in confidence may be shared, such as: suspected abuse; threat of harm to self or others; when information is needed for emergency medical treatment; when records are ordered by a judge; or if the patient waives confidentiality. Please see "Notice of Privacy Practices for Protected Health Information" for additional information.

Reminder calls: We will endeavor to send reminder calls prior to your appointment. Non-receipt of reminder call does not constitute cancellation of appointment, and missed appointments are subject to full appointment charges, even if no reminder call was made.

Cancellation policy: Missed appointments and appointments cancelled with less than 24 hours notice may be charged the full appointment fee.

Parent/Guardian Initials_____ Patient initials (if 14yo or older)_____ Date_____

GENERAL OPERATIONAL POLICIES AND PROCEDURES, page 2

ADA accessibility: Our office is ADA-accessible – please enter through the front door of the building.

Custody Determination/ legal proceedings: Our focus is on medical and therapeutic interventions. We are not geared toward custody determination and/or other related litigation.

I have read and understand the above information and I consent to treatment.

_____

Patient Name Date of Birth

_____

Signature (patients 14 and older) Date

_____

Signature (Parent/Guardian/legal representative Date

_____

Relationship to patient

Integrative Developmental & Behavioral Pediatrics, LLC

TELEHEALTH INFORMED CONSENT, page 1

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

PLEASE INITIAL BELOW:

_____ I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of Oregon at the time of this service.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined based on the duration of the visit and/or other care provided, and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
- Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
- Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

_____ I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

_____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____ I understand that Skype, FaceTime, Zoom, Doxy.me, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed if use of Microsoft Teams is not possible and I do not want to reschedule the appointment.

_____

Patient Name Date of Birth

_____

Patient signature (required if 14 years or older) Date

_____

Parent/Guardian/Legal Representative Date

_____

Printed Name and Relationship to Patient

Integrative Developmental & Behavioral Pediatrics, LLC

TELEHEALTH INFORMED CONSENT, page 2

_____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____ Integrative Developmental and Behavioral Pediatrics, LLC is not responsible for breaches of confidentiality caused by an independent third party or by me.

_____ I agree that I will verify to my healthcare provider my identity and I will let my provider know if my current location is outside of Oregon. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

_____ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

_____ I understand that electronic communication cannot be used for emergencies or time sensitive matters.

_____ I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

_____ I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

_____ I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

_____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

_____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

_____ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

_____ I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

_____I certify that I have read and understand this agreement.

_____

Patient Name Date of Birth

_____

Patient signature (required if 14 years or older) Date

_____

Parent/Guardian/Legal Representative Date

_____

Printed Name and Relationship to Patient

_____ _____

Patient Name Date of Birth

Integrative Developmental and Behavioral Pediatrics, LLC

FINANCIAL POLICY – for New Patients

We believe that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. PAYMENT: Payment in full is expected at the time of your visit. We will accept cash, check, or credit card. We require that a credit card be kept on file for the convenience of payment for services not provided in person (for example, video calls, telephone and email consultation, medical forms completion, missed appointments) or for non-payment of in-person services.

2. INSURANCE : We are not participating providers with any insurance plans (which means we are "out of network" for all insurances). We will provide you with a "Superbill" for services provided, which you may then submit to your insurance company for reimbursement. Please keep in mind that insurance does not usually reimburse for email and telephone consultation, sometimes does not reimburse for video appointments, and that prolonged service (more than 40 minutes for a follow-up visit and more than 60 minutes for a new patient visit) is sometimes not reimbursed by insurance.

3. RETURNED CHECKS will incur a $30.00 service charge and may be reported to collections. Stop payments constitute a breach of payment and are also subject to the $30 service fee and collections action.

6. FORMS FEES: We may require pre-payment for completing forms, copying medical records, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $10 per occurrence plus any applicable postage or notary fees. Copying fees for Medical Records are $10 for the first twenty (20) pages and $0.50 per page in excess of twenty. Please allow up to 15 business days for receipt of medical records.

7. CANCELLATIONS OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24 hours before, or if you no-show, your credit card may be charged the full appointment amount.

8. PAYMENT ARRANGEMENTS / CREDIT: Integrative Developmental and Behavioral Pediatrics, LLC does not make payment arrangements or extend credit. All services are expected to be paid in full at the time of service.

9. COLLECTION FEES: I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

Initials_____Date_____

FINANCIAL POLICY – for New Patients, page 2

10. DIVORCED PARENTS of PATIENTS: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about any treatment and/or payment issues.

11. APPOINTMENT/CONSULTATION FEES: Appointment charges are based on duration of appointment (most follow-up visits will be 40 minutes):

60 minute new patient appointment: $480

40 minute follow-up visit: $320

25 minute follow-up visit: $200

Visits lasting more than 60 minutes for a first-time visit, or 40 minutes for a follow-up visit, will incur additional charges, which will be calculated in 15 minute increments (in addition to the 60 or 40 minute appointment charge, there will be a $120 charge for each 15 minutes of additional time spent)

Video/telemedicine appointments will be charged at the same rate as in-office visits. Please be aware that insurance does not always reimburse for video appointments/telemedicine

Phone calls and email communication may be subject to charges based on amount of time spent ($120 for each 15 minute increment of time spent). Please be aware that insurance does not usually reimburse for phone call or email communication.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time and I may request updated copies of the practice's financial policy.

_____ _____

Signature of Parent/Guardian/Guarantor Date

_____ _____

Patient Name Date of Birth

_____ _____

Patient Name Date of Birth

Integrative Developmental & Behavioral Pediatrics, LLC

CREDIT CARD ON FILE POLICY

*PLEASE RETURN THIS FORM IN PERSON, BY US MAIL, OR BY SECURE/ENCRYPTED EMAIL. DO NOT FAX OR SEND BY REGULAR EMAIL

We require that we keep your credit or debit card on file as a method of payment for unpaid office visits, video appointments, medical form completion, and missed appointments.

Your credit card information is kept confidential and secure. You will be notified by telephone about any charges that may result from a missed appointment, form completion, returned check fees, or other service that was not provided in person. Charges will be processed either immediately after speaking with you, or no sooner than 48 hours after leaving a voicemail on the number you provided for appointment confirmation, whichever is sooner.

I authorize Integrative Developmental and Behavioral Pediatrics to charge the following credit or debit card for services provided:

☐ Amex ☐ Visa ☐ Mastercard ☐ Discover ☐ Other_____

Credit Card Number _____

Expiration Date _____ / _____ / _____

Security Code_____(3 digit # on back of card for Visa/MC/Discover, 4 digit code on front of card for Amex)

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

I (we), the undersigned, authorize and request Integrative Developmental and Behavioral Pediatrics to charge my (our) credit card, indicated above, for services rendered.

This authorization relates to all payments for services provided to me by Integrative Developmental and Behavioral Pediatrics. Another method of payment may be substituted at the time of service, if desired.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification in writing to Integrative Developmental and Behavioral Pediatrics, and the account must be in good standing.

_____

Patient or Patient's Representative Name (Print)

_____

Patient or Patient's Representative's Signature

Date_____/_____/_____

Integrative Developmental & Behavioral Pediatrics, LLC

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our office is permitted by federal privacy laws to make uses and disclosures of your health information without your express consent **for purposes of treatment, payment, and health care operations**. Protected health information (PHI) is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Use and Disclosure of Your Health Information for Treatment, Payment, and Health Care Operations
Each time you visit Integrative Developmental and Behavioral Pediatrics for health care, a record of your treatment is made. This record contains such information as registration information, including identification and billing information, and treatment information, including symptoms, diagnoses, test results, and treatment plans. This record is referred to as your "medical record" or "health information," and includes both written and electronic records.
Under the Health Insurance Portability and Accountability Act of 1996 (a Federal Law also known as "HIPAA"), Integrative Developmental and Behavioral Pediatrics, LLC providers are required to keep your information confidential and to provide you with notice of our legal responsibilities and privacy practices.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

To help clarify the terms in this document, here are some definitions:
"PHI" refers to *protected health information*, which is the information in your health record that could identify you.

- "*Treatment, Payment and Health Care Operations"*
  Treatment is the provision, coordination or management of your health care and other services related to your health care.
  Payment is when reimbursement is obtained for your healthcare.
  Health Care Operations are activities that relate to the performance and operation of Integrative Developmental and Behavioral Pediatrics.

- "*Use*" applies to activities within Integrative Developmental and Behavioral Pediatrics, LLC such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. Your health care information is used:
  To plan for your care and treatment
  For communication among your health care professionals
  As a medical document describing the care you received
  As a way for you or your insurance company to verify the services provided
  For other similar activities that allow Integrative Developmental and Behavioral Pediatrics, LLC providers to operate efficiently and provide you with quality care.

- "*Disclosure*" applies to activities outside of Integrative Developmental and Behavioral Pediatrics such as releasing, transferring, or providing access to information about you to other parties.

Use and Disclosure Requiring Authorization
Integrative Developmental and Behavioral Pediatrics, LLC may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when information is sought for purposes outside of treatment, payment and health care operations, an authorization will be requested from you before releasing this information.
You many revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that Integrative Developmental and Behavioral Pediatrics, LLC has relied on that authorization.

Uses and Disclosures which do not require Consent or Authorization

Your PHI may be released without your consent or authorization in the following circumstances:

- Treatment: Integrative Developmental and Behavioral Pediatrics, LLC providers may disclose your health information by phone, letter, fax, or computer to people who are not affiliated with Integrative Developmental and Behavioral Pediatrics, LLC but are involved in your medical care, such as your primary physician or a home health agency. An example of treatment would be when your clinician consults with another health care provider, such as your family physician or another clinician.
- Payment: Integrative Developmental and Behavioral Pediatrics, LLC may provide you with information to share with your health insurance plan about services you have received in order for you to receive reimbursement for those services. Integrative Developmental and Behavioral Pediatrics, LLC may bill the person in your family who is responsible for payment for services received at Integrative Developmental and Behavioral Pediatrics, LLC.
- Health Care Operations: Integrative Developmental and Behavioral Pediatrics, LLC may use your health information for administrative activities, or for accreditation, certification, or licensing purposes. Your health information may be used to review the performance of Integrative Developmental and Behavioral Pediatrics, LLC providers who are or have been involved in your care. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- Health Oversight: Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities for the purposes of monitoring our compliance with state and federal law to include audits, civil, administrative or criminal investigations: inspections; licensures or disciplinary actions; and for similar reasons related to the administration of healthcare.
- Judicial or administrative proceedings: If you are involved in a court proceeding, a lawsuit, or dispute, Integrative Developmental and Behavioral Pediatrics, LLC providers may disclose health information about you in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order or administrative tribunal, provided that only the protected health information released is expressly authorized by such order, or in response to a subpoena, discovery request or other lawful process.
- Appointment Reminders/ Additional Communications: Integrative Developmental and Behavioral Pediatrics, LLC may use your health information to call you or send you a letter reminding you of an upcoming appointment. Integrative Developmental and Behavioral Pediatrics, LLC providers may also use your information to call or send you the results of tests or to for other health communications such as treatment alternatives and other health-related benefits and services that may be of interest to you.
- Child Abuse: If there is reasonable cause to suspect that a child seen (or heard about) in the course of professional duties has been abused or neglected, or there is reason to believe that a child seen (or heard about) in the course of professional duties has been threatened with abuse or neglect, and/or that abuse or neglect of the child may occur, Integrative Developmental and Behavioral Pediatrics, LLC providers have a legal duty to report this to the relevant county department, child welfare agency, police, or sheriff's department. Investigations by relevant county department, child welfare agencies, police or sheriff's department may result in request for (and release of) treatment records and subsequent disclosure of PHI, including progress notes, to any agency investigating child abuse/neglect.
- Adult and Domestic Abuse: If your clinician believes that an elder person has been abused or neglected, such information will be reported to the relevant county department or state official of the long-term care ombudsman, as your clinician is a mandatory reporter of abuse and neglect.
- Serious Threat to Health or Safety: Integrative Developmental and Behavioral Pediatrics, LLC may use and disclose your health information when the provider believes the disclosure is necessary to prevent a serious threat to your health and safety or the health and safety of others. Integrative Developmental and Behavioral Pediatrics, LLC clinicians must warn the third party and/or take steps to protect you, which may include informing appropriate authorities.
- Law enforcement: We may disclose your protected health information for law enforcement purposes as required by law, such as when required by court order, including laws that require reporting of certain types of wounds or other physical injury.

Uses and Disclosures which do not require Consent or Authorization, continued

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death. Using our best judgment, we 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 in payment for such care if you do not object or in an emergency.
- We may use and disclose your protected health information to assist in disaster relief efforts.
- Controlling Disease: As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- Workers Compensation: If you file a worker's compensation claim, your records relevant to that claim to your employer or its insurer may be required to be released and your clinician(s) may be required to testify.
- Food and Drug Administration (FDA): We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.
- Specialized Governmental Functions: We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.
- Correctional Institutions: If you are or become an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.
- Coroners, Medical Examiners and Funeral Directors: We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.
- Other Uses and Disclosures: Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization which you may revoke except to the extent information or action has already been taken.

We may obtain services from business associates who provide appointment scheduling and reception services, transcription of dictation, quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, insurance, and other services. Integrative Developmental and Behavioral Pediatrics will share information about you with such business associates as necessary to obtain these services.

Patients' Rights and Duties of Integrative Developmental and Behavioral Pediatrics, LLC Providers

Patients' Rights:

- *Right to an Accounting of Disclosure*- You generally have the right to receive an accounting of disclosures of PHI. This right to accounting of disclosures does not include: Disclosures made to carry out treatment, payment and health care operations; Disclosures made to you; Disclosures made with your authorization; Disclosures made six years or more before the date your request is received. To request an accounting of disclosures, make your request in writing to Donna Kirchoff, MD. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care.
- *Right to a paper copy*- You have the right to obtain a paper copy of the most current Notices of Privacy Practices upon request, even if you have agreed to receive the notice electronically.
- *Right to request a restriction in certain uses and disclosures of your health information by delivering the request in writing to our office* – we are not required to grant the request, but Integrative Developmental and Behavioral Pediatrics will comply with any request that is granted.
- *Right to inspect and copy your health record and billing record* – you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request. There may be a charge for photocopying and/or mailing your medical record.
- *Right to request that your health care record be amended to correct incomplete or incorrect information* – you may exercise this right by delivering a written request to our office using the form we provide to you upon request. (The physician or other health care provider is not required to make such amendments); you may file a statement of disagreement if your amendment is denied, and you may require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
- *Right to confidential communication* – you may request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we give you upon request.

If you want to exercise any of the aforementioned rights, please contact Donna Kirchoff, MD, in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

Integrative Developmental and Behavioral Pediatrics, LLC's Duties:

- Integrative Developmental and Behavioral Pediatrics, LLC will maintain the privacy of your health information (PHI) as required by law and will provide you with a notice of our legal duties and privacy practices with respect to PHI (the information we collect and maintain about you).
- Integrative Developmental and Behavioral Pediatrics, LLC reserves the right to amend, change or eliminate provisions in the privacy policies and practices described in this notice. If our privacy practices or policies change, we will amend our Notice of Privacy Practices and you may request a revised copy in person, by email, or by phone. Unless you are notified of such changes, however, Integrative Developmental and Behavioral Pediatrics, LLC providers are required to abide by the terms of this notice and to notify you if we cannot accommodate a requested restriction or request.
- Integrative Developmental and Behavioral Pediatrics, LLC will accommodate your reasonable requests regarding methods to communicate health information with you, and accommodate your request for an accounting of disclosures as previously described.

Contact and Complaint Information

If you have questions, want additional information, or want to report a problem regarding the handling of your information, you may contact Donna Kirchoff, MD at (503) 444-1745.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Donna Kirchoff, MD. You may also file a complaint with the US Department of Health and Human Services by e-mailing your complaint to OCRComplaint@hhs.gov or by mailing your complaint to: Centralized Case Management Operations, US Dept. of Health and Human Services, 200 Independence Ave SW, Room 509F HHH Bldg., Washington DC 20201.

! We cannot, and will not, require you to waive the right to file a complaint with the US Department of Health and Human Services as a condition of receiving treatment from the office.

! We cannot, and will not, retaliate against you for filing a complaint with the US Department of Health and Human Services.

Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on Oct 21, 2016

Integrative Developmental and Behavioral Pediatrics, LLC reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI maintained and will provide you with a revised notice upon request if changes are made.

_____ _____

Patient Name Date of Birth

Integrative Developmental & Behavioral Pediatrics, LLC

RECEIPT OF PRIVACY PRACTICES

I understand that Integrative Developmental and Behavioral Pediatrics LLC (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By:_____ Date_____
(Patient – must be 14 years old to sign)

By:_____ Date_____
(Patient Representative)

Description of Representative's Authority:_____

Patient Name_____DOB_____

Integrative Developmental and Behavioral Pediatrics, LLC

CHILD HISTORY FORM (optional)

Many parents find that completing this form helps them organize information that is relevant to their child's difficulties. Completion of this form can also help increase the efficiency of the first visit, thereby decreasing cost. Please feel free to complete as much (or as little!) of the form as you feel will be helpful. If there is insufficient space for a complete response, feel free to add additional pages (please note on this form that you have included information on a separate page).

PARENT/GUARDIAN CONCERNS:

What are your main concerns regarding your child at this time?

What would you like your child to gain from our services?

If your child has been evaluated for developmental or behavioral concerns in the past, describe the nature of the evaluation(s), dates performed, and any school/medical professionals involved.

DEVELOPMENTAL CONCERNS:

Do you have concerns about your child's development in any of the following areas? Please circle any that apply:

Gross Motor Development	Fine Motor Development	Speech/ Language Development
Handwriting	Self Care Skills	Social Communication
Social Skills/Behavior	Attention	Sleeping
Sensory Processing Skills	Play	Eating
Toileting	Other (please describe):_____	

PREGNANCY & BIRTH HISTORY

Was pregnancy planned? yes / no When did prenatal care begin? _____

Any difficulties with conception? (ie IVF, donated egg or sperm, surrogacy) yes / no

If yes, please describe:_____

Who are the biological parents? _____

List any complications, illnesses, and/or accidents during pregnancy/labor/delivery:

Patient Name_____DOB_____

CHILD HISTORY FORM, page 2

PREGNANCY & BIRTH HISTORY, CONTINUED

List any prescriptions taken during pregnancy:

Known substance exposures during pregnancy: cigarettes alcohol drugs marijuana environmental toxins

Type of delivery: **vaginal c-section** Forceps used? **yes no** Vacuum used? **yes no**

Was the baby premature? yes no Gestational age at birth: _____ weeks

Baby's birth weight: Apgar scores (if known):

Was your child in the NICU? yes no If yes, how long?

Describe your initial bonding experience with your child:

Did either parent experience the "baby blues" (postpartum depressions)? yes no If yes, did they receive treatment? Please describe:

Describe any prolonged separations from parent(s) during infancy:

CHILD'S GENERAL HEALTH

Please describe the general state of your child's health:_____

_____

Please circle any of the following that are of concern to you:

General:	poor appetite	excessive appetite	excessive thirst
	overweight	underweight	difficulty sleeping
	excessive sleeping	confusion	fever
	loss of memory	no energy	behavior problems
	excessive energy		
Eyes:	eye pain	blurred vision	crossed eyes
	seen by eye doctor	eye itching	vision complaints
ENMT:	ear pain	hearing loss	loud snoring
	tooth pain	congestion	sneezing
	sore throat	bloody nose	
Respiratory:	hoarseness	persistent cough	wheezing
	difficulty breathing	exercise intolerance	

Patient Name_____DOB_____

CHILD HISTORY FORM, page 3

CHILD'S GENERAL HEALTH, CONTINUED

Please circle any of the following that are of concern to you:

Cardiovascular:	fatigue	chest pain	palpitations
	heart murmur	blue spells	fainting spells
Gastrointestinal:	abdominal pain	nausea	vomiting
	diarrhea	blood in stool	constipation
	stool in underwear	pain after eating	
Urinary:	painful urination	frequent urination	abnormal urine stream
	daytime wetting	bed wetting	urine color _____
	burning with urination	toilet trained	
Skeletal:	bone pain	joint pain	muscle pain
	weakness	back pain	swollen joints
	frequent fractures/breaks		
Neuromuscular:	headache	migraine	numbness
	loss of coordination	loss of balance	dizziness
	seizure	delayed development	jerks
	unexplained movements	tics/motor habits	
Psychiatric:	explosive	defiant	anxious
	temper tantrums	phobias / fears	transition difficulty
	hitting / biting	clingy / needy	resistant to bathing
	hyper active	under active	obsessions
	compulsions	hallucinations	delusions
	depression	suicidal	grandiose ideation
	hypersexual	boundary issues	sexual identity issues
Skin:	rash / acne	unexplained bruising	birth marks
	Itchy skin		

☐ Any other health concerns? Please describe:

Has your child ever lost consciousness or experienced a significant head trauma? yes no Please describe:

Has your child been hospitalized? yes / no Overnight? yes / no

If yes, for what and when:

Date of last well child exam: _____ Are immunizations up-to-date? yes / no

Any adverse reactions to vaccines? yes / no If so, please describe:

Patient Name_____DOB_____

CHILD HISTORY FORM, page 4

List medications (including vitamins and supplements) your child currently takes on a regular basis and indicate the reason for taking them:

What medications has your child taken in the past?

List any medication, environmental and/or food allergies (include symptoms that result with each allergy):

MOTOR DEVELOPMENT

At what age did your child accomplish the following developmental milestones? If you don't recall, but there were no concerns, please note "no concerns."

Rolled over	
Sat alone	
Belly crawled	
Crawled	
Pulled to stand	
Walked	

Has your child developed hand dominance? **yes no** If yes, **right** or **left**?

Does your child avoid using one side of his/her body? **yes no**

Does your child tend to have difficulty learning new motor tasks? **yes no**

Is your child resistant to participation in motor tasks? **yes no**

Any concerns with clumsiness/lack of coordination now? **yes no** If yes, please describe:

Any concerns about handwriting or drawing skills? **yes no** If yes, please describe:

Any concerns about ability to complete age-appropriate self-care skills from a motor skill standpoint? (bathing, brushing teeth, feeding self, etc)? **yes no** If yes, please describe:

If your child has been seen by an occupational or physical therapist in the past, please indicate when and where:

Patient Name_____DOB_____

CHILD HISTORY FORM, page 5

SENSORY DEVELOPMENT:

Please note any difficulty with processing sensory information in the following areas: If unsure, note "unsure"

Tactile_____

Auditory_____

Olfactory_____

Visual_____

Taste_____

Vestibular_____

Proprioceptive:_____

EMOTIONAL REGULATION:

Check any of the behaviors below which describe your child's emotional regulation as an *infant*:

☐ Used to cry/fuss a lot ☐ Was "good"/not demanding ☐ Was alert ☐ Was quiet/passive

☐ Used to drool excessively ☐ Used to resist being held ☐ Was floppy when held ☐ Was tense when held

☐ Was very active ☐ Had poor sleep patterns ☐ other_____

Check any of the behaviors below which describe your child's emotional regulation *now*:

☐ Is overly active ☐ Tires easily ☐ Is impulsive ☐ Is restless ☐ Has difficulties with change/transitions

☐ Has frequent temper tantrums ☐ Over-reacts to non-threatening situations/activities

☐ Other_____

ADAPTIVE FUNCTIONING:

Does your child require more support than expected for their age to accomplish activities of daily living (such as bathing, dressing, washing hair, washing hands, feeding, toothbrushing), separate from having difficulty with the motor skills required? **yes no** If yes, please describe:

ACADEMIC DEVELOPMENT:

Do you have any concerns about your child's academic performance? **yes / no If yes, please describe:**

Location and date of any previous academic testing_____

Does your child receive help from a tutor? If so, which subjects?_____

Patient Name_____DOB_____

CHILD HISTORY FORM, page 6

SPEECH-LANGUAGE DEVELOPMENT

Give approximate ages when your child:

UNDERSTOOD LANGUAGE

Knew own name ☐ by 8 months OR ☐ after 8 months OR ☐ unsure but no concerns

Responded to "no" ☐ by 12 months OR ☐ after 12 months OR ☐ unsure but no concerns

Followed 1-step directions ☐ by 18 months OR ☐ after 18 months OR ☐ unsure but no concerns

Recognized names of familiar objects ☐ by14 months OR ☐ after 14 months OR ☐ unsure but no concerns

Pointed to common pictures named ☐ by 18 months ☐ after 18 months OR ☐ unsure but no concerns

Answered "yes/no" questions ☐ by 18 months OR ☐ after 18 months OR ☐ unsure but no concerns

PRODUCED SPEECH-LANGUAGE

Began babbling ("ba-ba-ba") ☐ by 8 months OR ☐ after 8 months OR ☐ unsure but no concerns

Began to imitate sounds ☐ by 8 months OR ☐ after 8 months OR ☐ unsure but no concerns

Used first word ☐ by 14 months OR ☐ after 14 months OR ☐ unsure but no concerns

Had vocabulary of 10 words ☐ by 18 months OR ☐ after 18 months OR ☐ unsure but no concerns

Used 50 spontaneous words ☐ by 24 months OR ☐ after 24 months OR ☐ unsure but no concerns

Put 2 words together ☐ by 24 months OR ☐ after 24 months OR ☐ unsure but no concerns

Describe how your child lets you know what he/she wants or needs (or note " no concerns"):

List three sample sentences, phrases, or words your child currently uses (or note "no concerns"):

Approximately how much of what your child says do you understand (percent)?

☐none ☐ 10% ☐ 30% ☐ 50% ☐ 70% ☐ 90% ☐100%

Approximately how much of what your child says do unfamiliar listeners understand (percent)?

☐none ☐ 10% ☐ 30% ☐ 50% ☐ 70% ☐ 90% ☐100%

Please describe any concerns about social communication:

Does your child stutter or repeat words? **yes no** Make repetitive sounds for no obvious reason? **yes no**

If yes, please describe:

If your child has been seen by a speech therapist in the past, please indicate when and where:

Patient Name_____DOB_____

CHILD HISTORY FORM, page 7

PLAY:

What does your child enjoy doing in his/her free time?

HEARING

Do you feel or has it been suggested that your child has difficulty hearing? yes / no If yes, please describe:

Has your child's hearing been tested? yes / no

If yes, when?_____ Where?_____Results:_____

Is there a family history of childhood hearing loss? yes / no If yes, who? _____

Does your child have a history of ear infections? yes / no If yes, describe frequency:_____

How were your child's ear infections treated? _____

Has your child seen an Ear Nose & Throat doctor (ENT)? yes / no If yes, who?_____

Has your child had surgery on his/her ears? yes no

If yes, what kind and when?_____

Did/does your child wear hearing aids? yes / no cochlear implant? yes / no If so which ear/ears? left right

Make and model:_____

VISION DEVELOPMENT:

Do you have any concerns about your child's vision? yes / no If yes, please describe:

Location and date of any previous vision evaluation_____

Any history of vision therapy? yes / no If yes, where and when?_____

GENDER IDENTITY DEVELOPMENT:

With what gender does your child identify? male female other

Any concerns about gender identity? yes no

MEDIA/SCREEN USE:

Please note total daily hours of screen time. Weekday #hours/day_____ Weekend #hours/day_____

Describe type and amount of screen time (ie, TV vs phone vs tablet vs computer, and what type of programs are viewed on each media type):

Patient Name_____DOB_____

CHILD HISTORY FORM, page 8

TOILETING/ELIMINATION:

Is your child currently toilet-trained? yes / no If yes, since what age?_____

What is your child's typical bowel pattern? ____ time(s) a day.

Does your child experience: ☐ daytime accidents ☐ bedwetting ☐ constipation ☐ frequent loose stools ☐ unusually foul odor to stools

Did your child toilet train easily? yes no If not, please describe:

FEEDING:

Give approximate ages when your child:

Ate solid foods_____(or circle: unsure but no concerns)

Drank from open cup, unassisted:_____ (or circle: unsure but no concerns)

Fed self with fingers:_____ (or circle: unsure but no concerns)

Fed self with utensils:_____ (or circle: unsure but no concerns)

Did your child explore toys orally as an infant? yes no

Was your child breast-fed? yes no If yes, how long? Bottle-fed? yes no If yes, how long?

Any problems with breast or bottle-feeding? yes no If yes, please explain

Describe any feeding difficulties (past/present):

Does your child currently use a bottle or sippy cup? yes no or pacifier? yes no
Current appetite (please circle one): poor fair good

Check any feeding difficulties your child has now, or had in the past ☐ sucking ☐ chewing ☐ choking ☐ swallowing ☐ accepting new foods ☐ over-stuffing mouth ☐ strong likes/dislikes for certain foods ☐ picky ☐ overeats ☐ refuses to eat ☐ hoards food ☐ gags/vomits ☐ eats non-food items
☐ Other:

Does your family eat together at least once a day? yes no

Does your child remain seated at the table throughout the meal? yes no

Does your child experience significant drooling? yes no

Does your child tolerate toothbrushing well? yes no

How is your child's food prepared? ☐ Whole foods ☐ cut up ☐ chopped ☐ fork mashed ☐ puree

Please describe your child's diet, including any food allergies, aversions/picky eating or special diet (past or present):

Patient Name_____DOB_____

CHILD HISTORY FORM, page 9

SLEEP:

Where does the child sleep ☐ solo (own bed) ☐ with parent ☐ with sibling

Does s/he sleep in a room alone or share a room with sibling/other?_____

Bedtime: _____ Average number of hours of sleep each night?_____

Naps? yes no If yes, for how long?_____

Sleep disturbances: ☐ reluctance to go to bed ☐ restless during the night ☐ bad dreams ☐ frequent waking ☐ difficulty in getting to sleep ☐ talks/cries in sleep ☐ snoring/irregular breathing ☐ difficulty getting up in the morning ☐ other concerns related to sleep behaviors (please describe):

FAMILY HISTORY

Please note any family history of the following, especially in siblings, parents, aunts, uncles, cousins or grandparents (please include how the person is related to your child with each positive response – ie maternal aunt, paternal grandfather):

Heart problems (especially under age 60):_____
-ie heart attack, arrythmia, congenital heart disease, sudden cardiac death, valve problems

Lung problems:_____
-ie asthma, cystic fibrosis, other breathing problems

Kidney problems:_____
-ie recurrent urinary or kidney infections, kidney stones, kidney failure, abnormalities of the kidney

Liver problems:_____
-ie hepatitis (infectious or autoimmune), other diseases impacting liver function

Skin problems:_____
-ie eczema, psoriasis, vitiligo

Gastrointestinal problems:_____
-ie constipation, diarrhea, celiac disease, Inflammatory Bowel Disease, Chron's Disease, Ulcerative Colitis, irritable bowel, SIBO

Neurologic problems:_____
-ie seizures, movement disorders, multiple sclerosis, Tourette's Syndrome or tics, cerebral palsy

Allergies:_____
-ie to foods, environmental, medication or other

Immune problems (including autoimmune):_____
-ie Type 1 Diabetes, rheumatoid arthritis, thyroid disease, frequent infections, or more severe infections than expected when sick, other autoimmune diseases

Bleeding problems:_____
-ie easy bruising/bleeding, hemophilia, VonWIllebrand's

Cancer:_____
-especially in people less than 50yo

Patient Name_____DOB_____

CHILD HISTORY FORM, page 10

FAMILY HISTORY, CONTINUED

Psychiatric diagnosis OR SYMPTOMS:_____
-ie diagnosis or symptoms of autism, Asperger's, depression, anxiety, OCD, ADHD, ADD, bipolar/manic-depression, schizophrenia, personality disorders

Other_____
-ie any other medical or mental health condition not already described above

SOCIAL HISTORY

What activities does your family most enjoy doing together?

What kids of supports do you have? (ie family, friends, spiritual, community or government programs/services, babysitters/caregivers)

What are the major stressors for your family?
(ie job stress, impact of child's special needs/behavior on family, stress in relationship between parents/caregivers, financial stressors, mental/physical health difficulties of other family members, needs of extended family, relational stressors with extended family/friends, lack of support from family/friends)

What do parents do for work? (note: being a full time caregiver is very important work!)

LABS/IMAGING/EKG:

Have labs or imaging or EKG ever been done? If so, please indicate where and when (if you have copies of results, please include them with this form):

OTHER TESTING/EVALUATIONS:

Please list any other testing/reports/evaluations not already described (if you have copies of results, please include them with this form):