Four Seasons Pediatrics
Physical exam form for 18, 24 and 30 month

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

Feeding History:

How many ounces of milk does your child drink each day? _____
Does he/she eat most table foods? _____
Does he/she use a spoon and cup okay? _____
Any problems with eating? _____

Behavior:

Any problems with his/her sleeping? _____
Does your child have any difficult behavior you would like to change?
_____
Does your child have to be spanked frequently? _____
Is your family having any serious problems?

Illnesses:

If your child is on medicines, name them: _____
Has your child had any serious illnesses since the last check up? _____

Development:

Please check the boxes to indicate if your 18 month old does the following:

__ Scribbles with a crayon
__ Walks well
__ Runs with legs stiff
__ Can hurl a ball
__ Says about 10 words
__ Uses a pull toy
__ Turns pages, 2-3 at a time

Please check the boxes to indicate if your 2 year old does the following:

__ Puts 2-3 words together
__ Can walk up stairs
__ Can kick a large ball
__ Turns pages one at a time
__ Points to body parts
__ Uses words: "I, me, you"
__ Imitates you at home
__ Pulls up pants, puts on socks

Please check the boxes to indicate if your 30 month old does the following:

__ Imaginary play is increasing
__ Uses short phrases of 3-4 words
__ Has friends
__ Brushes teeth with help
__ Expressing fearfulness
__ Is understandable to others 50% of the time
__ Throws ball overhand
__ Puts on clothes with help

Social:

Are both parents living at home? _____
Does your child brush his/her teeth every day? _____
Is your child taking fluoride? _____

Screening – Please check the box if any of the following are true:

__ My child has had exposure to tuberculosis or a person with a positive skin test
__ My child spends a significant amount of time in a home built before 1960
__ There is a family history of high cholesterol of > 240 in either parent or grandparents
__ There is a family history of heart disease before 55 in either parent or grandparents
__ There are concerns with family mental health history or substance abuse
__ There are barriers to communication of health information, such as vision, hearing or cognition
__ The family has concerns about meeting daily needs, income, paying for medications, ect.

PLEASE SEE QUESTIONS ON OPPOSITE SIDE

M-CHAT

Patient Name: _____ DOB:_____ Today's Date: _____

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

1. Does your child enjoy being swung, bounced on your knee, etc.? ___ Yes ___ No

2. Does your child take an interest in other children? ___ Yes ___ No

3. Does your child like climbing on things, such as up stairs? ___ Yes ___ No

4. Does your child enjoy playing peek-a-boo/hide-and-seek? ___ Yes ___ No

5. Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things? ___ Yes ___ No

6. Does your child ever use his/her index finger to point, to ask for something? ___ Yes ___ No

7. Does your child ever use his/her index finger to point, to indicate interest in something? ___ Yes ___ No

8. Can your child play properly with small toys (e.g. cars or bricks) without just mouthing, fiddling, or dropping them? ___ Yes ___ No

9. Does your child ever bring objects over to you (parent) to show you something? ___ Yes ___ No

10. Does your child look you in the eye for more than a second or two? ___ Yes ___ No

11. Does your child ever seem oversensitive to noise? (e.g., plugging ears) ___ Yes ___ No

12. Does your child smile in response to your face or your smile? ___ Yes ___ No

13. Does your child imitate you? (e.g., you make a face-will your child imitate it?) ___ Yes ___ No

14. Does your child respond to his/her name when you call? ___ Yes ___ No

15. If you point at a toy across the room, does your child look at it? ___ Yes ___ No

16. Does your child walk? ___ Yes ___ No

17. Does your child look at things you are looking at? ___ Yes ___ No

18. Does your child make unusual finger movements near his/her face? ___ Yes ___ No

19. Does your child try to attract your attention to his/her own activity? ___ Yes ___ No

20. Have you ever wondered if your child is deaf? ___ Yes ___ No

21. Does your child understand what people say? ___ Yes ___ No

22. Does your child sometimes stare at nothing or wander with no purpose? ___ Yes ___ No

23. Does your child look at your face to check your reaction when faced with something unfamiliar? ___ Yes ___ No

M-Chat reviewed and scored by: _____ Date: _____

Vision Photoscreening (CPT-99174)

In January 2016, the American Academy of Pediatrics recommended that instrument based vision screening (known as Photoscreening) "should be first attempted between 12 months and 3 years of age and at annual well child visits until acuity can be tested with a wall chart"

Four Seasons Pediatrics has evaluated this technology and we have started screening as recommended by the American Academy of Pediatrics. You may see this recommendation at the following link:

http://pediatrics.aappublications.org/content/early/2015/12/07/peds.2015-3596

Some insurance plans have been identified that do not consider this service preventative or do not cover outright the cost of this screening tool. We do not alter our evidence based recommendations due to insurance coverage and therefore still recommend that this be done. This instrument uses a computer based program to detect conditions that may lead to permanent vision loss known as amblyopia**.** You have the option to have the screening and if it is not covered as a preventive service, we will appeal your denial and ask that the insurance company update their policy to reflect current recommendations. If unsuccessful, we want to make you aware that you may be responsible for payment for anywhere from $5 to $38.17* (*the billed amount of this service) depending on your policy. Another option is to use a non computer based photoscreening, which is provided as a free service if you travel to the Northeast Association for the Blind in Albany. You may set up an appointment by calling 518-463-1211

Notice to Tricare subscribers and insured patients: I am hereby requesting that the following services be provided to me by Four Seasons Pediatrics. In making this request, I acknowledge that these services are not a benefit of my health coverage under TRICARE and that I will not receive the benefit of the TRICARE Hold Harmless Policy (defined below), which otherwise might apply to me. In addition, I acknowledge that if I have obtained services more frequently than authorized by TRICARE policy, I may be responsible for that professional service. I also understand that if authorization for this care has been denied by TRICARE, or if reimbursement is denied upon submittal of a claim form, I may appeal the written notification of the denial issued by Health Net Federal Services, Inc./MHN Services. Unless the decision to deny is overturned as the result of an appeal or dispute, I agree that I will be personally responsible for the payment IN FULL of the billed charges for these services. **TRICARE Hold Harmless Policy:** A network provider may not require payment from the beneficiary for any excluded or excludable services that the beneficiary received from the network provider (i.e., the beneficiary will be held harmless) unless the beneficiary has been properly informed that the services are excluded or excludable and has agreed in advance in writing to pay for the services.

□ I understand the above and would like my child screened
□ I decline the screening and will consider screening at NABA. I understand that if not screened, it may result in later detection of vision problems leading to amblyopia

_____ _____/_____/_____
Patient Name DOB

_____ _____
Print Name Relationship to patient

_____ _____
Parent/Guardian/Subscriber Signature Date

□ I would like a copy of this statement provided to me