

## Parent Packet A

Patient Name \_\_\_\_\_  
DOB \_\_\_\_\_

Dear Parents:

The following forms will help us in the evaluation of your child's school related difficulties. We'd like to ask your help in order to make the process go smoothly. If you are filling this out electronically, please note that the form fields may be typed in for the fill in the blank answers. You will be able to tab between fields. You will also need to login to your Four Seasons Pediatrics Web Portal and click on the CHADIS button within the Milestones Tile. There will be additional questionnaires there, as well as those for the teacher.

It would be helpful to us if you would mail, email or deliver the enclosed completed forms to our office at least a week BEFORE the appointment date. You may email this to [exchange@fourseasonspediatrics.com](mailto:exchange@fourseasonspediatrics.com). This includes all items in this packet. In addition, you need to sign the 2 medical release forms at the front of both packets and give "School Packet B" with one of the signed forms to your child's school for them to complete and send to us.

Our evaluation will begin with an appointment to discuss your child's problem(s) and to review the medical history. We will do a physical exam. Sometimes, we may suggest laboratory or psycho-educational testing. We will go over any questions, review our impressions, and think together about a plan to improve your situation. Although sometimes, you may feel pressured to do something now, we suggest that we get the information necessary to make the right decision. This may sometimes lead to some time delay to do this, but important decisions require that we have the essential information.

Please return the completed forms and mail them to:

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**PLEASE ENTER NAME OF DOCTOR**  
Four Seasons Pediatrics  
532 Moe Road \* Clifton Park, NY 12065 \* Telephone 383-2425

Thanks for your help in providing this information. We look forward to your upcoming visit.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Teacher: \_\_\_\_\_ School: \_\_\_\_\_

**History of the Present Problem:**

When was this problem first noticed, and how has it progressed since then?

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Is there anything that you feel might be making this problem worse?

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What has been tried to improve the problem?

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How well do you think the school understands your child's problem?

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How do you feel we can be of help to you? (And/or list any specific questions you feel this evaluation should address)

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**Review of Systems:**

Has your child appeared anxious or shown signs of depression or sadness?

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Has your child been exposed to violence, physical or sexual abuse?

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Do you have any concerns about how your child is learning, developing and behaving? If yes, please explain.

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Would you describe your child as affectionate?    Yes or    No (Explain if no)

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**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Past Medical History:**

Birth Weight: \_\_\_\_\_ Was your child premature? \_\_\_\_\_  
Any medications, smoking or alcohol during the pregnancy? \_\_\_\_\_  
Any problems during or after the pregnancy? \_\_\_\_\_  
Any significant past medical problems? \_\_\_\_\_  
As an infant was there any problems with:  
Feeding? \_\_\_\_\_  
Sleeping? \_\_\_\_\_  
At what age did your child:  
Walk? \_\_\_\_\_  
Talk? \_\_\_\_\_  
Toilet Train? \_\_\_\_\_  
Any possible exposure to lead from old paint or other sources? \_\_\_\_\_

**Family History:** Please check off all that are appropriate:

\_\_\_ ADD                      \_\_\_ Alcoholism                      \_\_\_ Learning Disability  
\_\_\_ Seizures                      \_\_\_ Substance Abuse                      \_\_\_ Conduct Disorder  
\_\_\_ Obsessive-Compulsive Disorder                      \_\_\_ Tic/Tourette Syndrome  
\_\_\_ Psychiatric History

Are there any significant stresses that your child has been under?

**Developmental History:**

When your child was 18 to 24 months old; did your child have a nighttime routine? If yes, did he like to be read to? \_\_\_\_\_

When your child was between 2-5 years old, was there any problem taking him in public places? If yes, what were they? \_\_\_\_\_

**School History:** Please answer if your child's age is appropriate to answer:

Were there any problems in Kindergarten or 1<sup>st</sup> grade? If yes, what were they?

Were there any problems in 2<sup>nd</sup> or 3<sup>rd</sup> grade? If yes, what were they?

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

CD		3 / 12 months		
1.	Does not seem to listen when spoken to directly?	Never	Rarely	Often
2.	Initiates physical fights?	Never	Rarely	Often
3.	Has used a weapon in a fight that can cause serious physical harm to others (e.g. bat, brick, broken bottle, knife, gun)?	Never		Once
4.	Has been physically cruel to people?	Never	Once	More than once
5.	Has been physically cruel to animals?	Never	Once	More than once
6.	Has stolen while confronting a victim (e.g. mugging, purse snatching, extortion, robbery)?	Never		Once
7.	Has forced someone into sexual activity?	Never		Once
8.	Has deliberately engaged in fire setting with the intention of causing serious damage?	Never		Once
9.	Has deliberately destroyed others' property (other than by fire setting)?	Never		Once
10.	Has broken into someone else's house, building or car?	Once		Once
11.	Lies to obtain goods or favors or to avoid obligations (i.e. cons)?	Never	Rarely	Often
12.	Has stolen items of nontrivial value without confronting a victim (e.g. shoplifting without breaking and entering, forgery)?	Never		Once
13.	Stays out at night despite parents prohibiting, beginning before age 13 years?	Never	Rarely	Often
14.	Has run away from home overnight while living in home?	Never	Once	More than once
15.	Is truant from school, beginning before age 13 years?	Never	Rarely	Often

Lang				
1.	Trouble expressing thoughts?	Rarely	Sometimes	Always
2.	Difficult to understand/follow directions?	Rarely	Sometimes	Always
3.	Tends to express himself through gestures rather than verbally?	Rarely	Sometimes	Always
4.	Trouble finding the correct word?	Rarely	Sometimes	Always
5.	Confuse words that sound alike (eg, tornado for volcano)?	Rarely	Sometimes	Always

LD				
1.	Problems with naming letters of the alphabet?	Never	Rarely	Often
2.	Problems with identifying words that begin with the same letter?	Never	Rarely	Often
3.	Problems recalling a sentence or story that was just told?	Never	Rarely	Often

AD (2/1)				
1.	Problems with making eye contact or other nonverbal behaviors such as facial expressions, body postures, and gestures that help interacting with others?	Never	Rarely	Often
2.	Difficulty developing relationships with others his/her age?	Never	Rarely	Often
3.	Difficulty sharing enjoyment, interests with other people (e.g. by a lack of showing, bringing, or pointing out objects of interest to other people?	Never	Rarely	Often
4.	Difficulty responding to others when they show a social interest?	Never	Rarely	Often
5.	Seems very pre-occupied with certain interests to the exclusion of other things?	Never	Rarely	Often
6.	Seems inflexible to certain routines, gets upset when they are changed?	Never	Rarely	Often
7.	Seems to have a pre-occupation with parts of objects?	Never	Rarely	Often

**PERMISSION TO EXCHANGE MEDICAL AND SCHOOL INFORMATION  
(FOR PATIENT's MEDICAL RECORD)**

I, \_\_\_\_\_ authorize Four Seasons Pediatrics to exchange information with  
\_\_\_\_\_ (name of school) regarding \_\_\_\_\_ DOB \_\_\_\_\_  
(Patient name and date of birth)

In order to facilitate communication between my child's school and my doctor, I hereby give permission for sharing of medical, social, personal, and educational information relevant to the care and treatment of my child's learning difficulties.

I understand that my permission is required to release any information related to psychiatric and emotional health, sexual abuse, and/or drug and alcohol use, and I do grant permission for including such information if relevant in the care and treatment of my child's medical condition.

I understand that the confidentiality of these records will be protected. These records cannot be disclosed without written consent, except as provided for under Federal or State of New York laws. I also understand that this consent can be revoked at any time, except to the extent that action has been taken. I further acknowledge that I understand the purpose of this release and consent is given of my own free will.

\_\_\_\_\_  
Signature and relationship of individual authorizing release

\_\_\_\_\_  
Date

Thank you for completing these forms. Please do not forget to sign the release on the school packet (B) and give this to the school. We need one for our records and the second is for the school!