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A Medical Corporation

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CHILD AND ADOLESCENT MEDICAL SCREENING

PATIENT'S NAME:

DATE of BIRTH: ______/______/______ **SOCIAL SECURITY #:**

NAME OF PARENT(S):

ADDRESS:

TELEPHONE: home: work:

fax: email:

cell:

Other contact information:

Primary Care Physician: SPECIALTY PHONE

Referring Psychiatrist/Psychologist: SPECIALTY PHONE

CHIEF COMPLAINT (SPECIFY ONSET AND DURATION):

MEDICATION(S) (specify dosage, route, frequency, reason for prescription, and duration of treatment):

MEDICATION ALLERGIES? ☐

Gestational History

During this pregnancy did the mother have: ☐ anemia ☐ elevated blood pressure ☐ swollen ankles

☐ kidney diseases ☐ heart disease ☐ bleeding ☐ measles ☐ German measles ☐ flu

☐ other virus ☐ vomiting ☐ injury ☐ medication during pregnancy ☐ emotional problems

☐ threatened miscarriage or early contractions

☐ other illness:

Describe:

In the 6 months preceding this pregnancy did the mother have exposure to:

☐ drugs or alcohol ☐ x-rays

Describe:

PERINATAL HISTORY

1. Where was the patient delivered?
2. What type of delivery was used?
3. What complications were encountered in the delivery?
4. What was the baby's birth weight?
5. What was the baby's condition at birth; what was the Apgar score?
6. What problems did the mother experience at delivery or just afterwards?

Developmental History

1. When did the baby turn over?
2. When did the baby sit alone if placed in this position?
3. When did the baby get to a sitting position unaided?
4. When did the baby crawl?
5. When did the child stand?
6. When did the child walk?
7. Did your child walk on his/her toes to a conspicuous degree, and does he/she still do this?
8. What other gait problems have been present?
9. When did your child feed him/herself with his/her fingers:
   with utensils: with a cup:
10. When did your child learn to undress him/herself: put on outer garments
    manage buttons, zippers, and laces:
11. When was your child fully toilet trained (bladder and bowel, day and night)?
12. What difficulties were encountered in these areas of training?
13. When did your child use single words: Phrases: Sentences:
14. How clear or well formed was speech. and how is it presently utilized? Is it meaningful speech?

Development relative to peers:	Normal Progress	Lagging Behind	Loss of Prior Skills
Gross Motor Skills	☐	☐	☐
Fine Motor Skills	☐	☐	☐
Handwriting	☐	☐	☐
Intellect	☐	☐	☐
Language	☐	☐	☐
School Performance	☐	☐	☐

Immunizations current?

☐ Polio Date: ☐ Rubeola Date:

☐ Rubella Date: ☐ DPT Date:

PAST MEDICAL HISTORY

Has your child ever been hospitalized? When and for what reasons?

Doctor:

What feeding problems were encountered in the past?

Did the baby have colic? ☐ NO ☐ YES:

Have there been any intestinal problems? ☐ NO ☐ YES, PLEASE EXPLAIN:

Chronic diarrhea? ☐ NO ☐ YES:

Constipation? ☐ NO ☐ YES:

Fecal retention? ☐ NO ☐ YES:

Fecal soiling? ☐ NO ☐ YES:

Have there been any significant injuries, illnesses, or operations? ☐ NO ☐ YES:

How did the child sleep and what sleep problems are now evident?

Does hearing seem adequate by the parents' standards? ☐ YES ☐ NO:

Has anyone else questioned the patient's hearing ability? ☐ YES ☐ NO

Has there been any illness involving the ears? ☐ NO ☐ YES:

What eye problems has the child had?

Has the patient used glasses; has there been any strabismus; has there been any eye therapy? ☐ NO ☐ YES:

Has the patient experienced any seizures, with or without fever? ☐ NO ☐ YES:

Have there been any trance-like episodes or minor lapses which could be petit mal or other seizure fragments?
☐ NO ☐ YES:

Has the child been excited by medications which would normally be sedative in nature or without anticipated psychotropic effect? ☐ NO ☐ YES:

Has there been: excessive urination? ☐ NO ☐ YES:
excessive fluid intake? ☐ NO ☐ YES:
bed wetting? ☐ NO ☐ YES:
urinary tract infection? ☐ NO ☐ YES:

What neurological complaints are present, such as headache, vomiting, poor balance, double vision, dizziness. weakness, numbness. etc.?

Have there been severe or repeated blows to the head? ☐ NO ☐ YES:

Girls: Age of onset of menses: Is menstruation regular? ☐ YES ☐ NO:

Family History of:

☐ Learning problems or behavioral disturbances
☐ Abortions (2 for anyone mother)
☐ Stillbirths
☐ Congenital anomalies
☐ Mental retardation
☐ Neurological disorders
☐ Other (list)

Physical Features

Height:
Weight:
Normal Growth Rate this Past Year in: Height: ☐ YES ☐ NO Weight: ☐ YES ☐ NO
Blood pressure ☐ normal ☐ high ☐ low

NAME OF PARENT:
Relationship to Patient:
SIGNATURE: **DATE: ______/______/______**

Comments (continue on reverse):

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

Vernon A. Rosario II, MD, PhD
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Los Angeles, CA 90024 310-470-9775

I hereby acknowledge that I reviewed and downloaded a copy of this medical practice's *Notice of Privacy Practices* on-line at:

http://vrosario.bol.ucla.edu/forms/HIPAA_PatientNotice.pdf

I further acknowledge that a copy of the most current notice will be available on-line
A print copy of the current Notice of Privacy Practices will be available at each appointment upon request.

Signed: ______________________________Date: __________________________________
Print Name: __________________________Telephone: _____________________________

If not signed by the patient, please indicate relationship:

❑ Parent or guardian of minor patient
❑ Guardian or conservator of an incompetent patient

Name and Address of Patient: ____
____
____