Parents, please complete to the best of your ability.

SILVER LAKE PEDIATRICS
33017 PROFESSIONAL DRIVE
LEESBURG FL 34788
352-314-2275

MEDICAL HISTORY FORM

Person completing this form:_____ Date_____

Relationship to child:_____ Child's primary language:_____

Child's Name:_____ Sex:_____ Date of Birth:_____

Mailing Address_____

City_____ County_____ State_____ Zip_____

Home Phone ( )_____

Child's Primary Care Physician (PCP) Name:_____

Mailing Address_____

City_____ County_____ State_____ Zip_____

Office Phone ( )_____ Who referred you to this clinic_____

Specific Concerns

What specifically concerns you about your child? Describe your concerns and what you hope to gain from the evaluation?

_____

_____

_____

_____

_____

_____

When were you first aware of this problem?

_____

Has your child been previously evaluated? By whom? What were you told about your child's problem?

_____

_____

_____

Composition of Family in which child currently resides:

Mother's Name_____ Age_____

Relationship: Biological ☐ Adoptive ☐ Step ☐ Foster ☐ Other ☐ _____

Education:_____

Occupation:_____

Address of Employment:_____

Home Phone ( )_____ Work Phone:( )_____

Can you be contacted at work? Yes ☐ No ☐ Approximate annual gross income?_____

Father's Name_____ Age_____

Relationship: Biological ☐ Adoptive ☐ Step ☐ Foster ☐ Other ☐ _____

Education:_____

Occupation:_____

Address of Employment:_____

Home Phone (__) _____ Work Phone:(__) _____

Can you be contacted at work? Yes ☐ No ☐ Approximate annual gross income?_____

Who is the child's legal guardian?_____

Persons residing in the home with child:

Name	Age	Sex	Relationship

If parent works, who cares for child?_____

Events In Family:

Have any of the following events occurred in the child's immediate family in the past year?

Family moved?	Yes ☐	No ☐
Death, divorce, separation, loss of family member?	Yes ☐	No ☐
Marriage, reconciliation, pregnancy, a new family member?	Yes ☐	No ☐
Serious injury or illness, problems with aging relatives?	Yes ☐	No ☐
Loss of work, change jobs, retirement?	Yes ☐	No ☐
Frequent serious arguments or fights?	Yes ☐	No ☐
Money problems?	Yes ☐	No ☐
Sex problems?	Yes ☐	No ☐
Drug or drinking problems?	Yes ☐	No ☐
Involvement with social services?	Yes ☐	No ☐
Out of home placement of the child?	Yes ☐	No ☐
Serious trouble with the law?	Yes ☐	No ☐
Mental illness?	Yes ☐	No ☐
Some other serious problem? (If yes, what?_____)	Yes ☐	No ☐

Agency involved:_____ Caseworker:_____

Explanation of items marked "yes":_____

Family History

Is there any history on either side of the child's biologic parents' family of the following? If yes, indicate FATHER'S or MOTHER'S side and explain WHO in remarks section showing the item number.

Item	Item Description	No	Yes	Mother's	Father's	Remarks
1	Psychological/psychiatric emotional					
2	Mental Retardation					
3	Learning Problems					
4	Birth Defects (C.P., etc...)					
5	Seizures/Convulsions					
6	Tuberculosis					
7	Neurological Disease					
8	Diabetes					
9	Cancer					
10	Allergies/asthma					
11	Gland disorders/thyroid					
12	Hearing disorders					
13	Vision					
14	Hyperactivity					
15	Miscarriages					
16	Slow development					
17	Speech problems					
18	Other diseases in family					

All Pregnancies (include patient, deceased or miscarriages) in order:

No.	Birth Weight	Current Age	Current Grade	Health or Developmental Problems/Comments

Concerning the child being evaluated:

Did you receive prenatal care? Yes ☐ No ☐

During which month did you start prenatal care?_____

Did you smoke cigarettes during your pregnancy? Yes ☐ No ☐ If yes, how many per day?_____

Did you drink alcohol during your pregnancy? Yes ☐ No ☐ If yes, number of drinks per week?_____

Did you use any narcotic or prescription drugs during or before your pregnancy? Yes ☐ No ☐

If yes, which ones?_____ How often?_____

Did any of the following occur during pregnancy? (Check those which DID occur)

☐	decreased fetal movement	☐	morning sickness	☐	swelling
☐	high fever	☐	amniocentesis	☐	stressful events
☐	x-rays	☐	hospitalization	☐	significant trauma
☐	ultrasound	☐	operations	☐	special diet
☐	stress test	☐	accidents	☐	vaginal bleeding
☐	diabetes	☐	toxemia	☐	unusual worries
☐	high blood pressure	☐	premature labor	☐	any other problem(s)

Please explain the items you checked: _____

_____

_____

Child's Birth

At birth of child - Mother's age:_____ Father's age_____

Place of child's birth: Hospital name_____

Address_____

Physician's Name_____

Was the baby born on time?_____Late?_____ Early?_____ How many weeks?_____

Any problems with labor or delivery? Yes ☐ No ☐ Explain _____

_____

_____

Type of anesthesia/pain relief/sedation_____

Delivery was by: vaginal/natural _ C-section ____ planned _____ emergency ____breech _____ forceps_____

How many days in hospital?_____

Infant's condition at birth and in nursery:_____

Birth weight: _____ Birth length: _____ Head Circumference: _____

APGAR scores: _____

Please explain anything additional or exceptional about the birth or newborn period of your child: _____

_____

_____

Developmental History

Developmental Milestones: State the age when your child first did each of the following. Say "No" if your child has not yet done it. If you do not remember, leave it blank.

Smiled _____

Held head erect _____

Rolled over _____

Sat alone _____

Crawled _____

Walked alone _____

Rode tricycle _____

Rode bicycle _____

Ate unaided with spoon _____

Separated easily from mother _____

Buttoned clothes _____

Dressed self _____

Imitated sound _____

Said "mama", "dada" _____

Said other single words _____

Said 2-3 word phrases _____

Followed simple directions _____

Knew colors _____

Started counting _____

Recited total alphabet _____

Did you feel your child developed quickly? _____ or slowly? _____

Temperament

Please rate the following behaviors as your child appeared during infancy and toddlerhood:

Activity level - How active was your child? _____ How distractible? _____

_____

_____

Adaptability - How well did your child deal with transition and change? _____

_____

_____

Approach/Withdrawal - How well did your child respond to new places, people, and things? _____

_____

_____

Intensity - Was your child happy or unhappy? _____ Do adults notice how your child is feeling? _____

_____

Mood - What was your child's basic mood? (Check one) Happy? ☐ Sad? ☐ Angry? ☐ Quiet? ☐

Regularity - Was your child predictable in patterns of sleep, appetite, etc...?

Child's Medical History

We need as complete a medical history of your child as possible. Please complete this part. Explain any items checked "YES" in the explanation space and include as much information as possible about the item. Use more paper if necessary.

Has child ever been treated for or had a history of:

No.	Item Description	No	Yes	Explanation
1	Abdominal pain/bowel problems			
2	Allergies, including foods or drugs			
3	Anemia			
4	Birth Defects			
5	Concussion/significant head injury			
6	Dental problems			
7	Drooling			
8	Ear Infections			
9	Eating problems			
10	Headaches			
11	Hearing loss			
12	Heart condition			
13	Hemorrhaging or blood disorders			
14	Hormone problems			
15	Ingesting toxins/poisons			
16	Joint or bone problems			
17	Muscular problems			
18	Seizures or convulsions			
19	Significant accidents			
20	Skin diseases			
21	Tics (eye blinking, any non-purposeful repetitive movement)			
22	Urinary problems or infections			
23	Lung or breathing problems			
24	Visual/eye problems			
25	Other			

Hospitalizations: List any hospitalizations, operations or accidents of child._____

_____

_____

Medications: List medication child currently takes:_____

_____

_____

Current Weight _____ Current Height _____

Has child been immunized? Yes ☐ No ☐ Up to date?_____

Educational History

List pre-schools and schools this child has attended:

School:	Dates:
_____	_____
_____	_____
_____	_____
_____	_____

Has this child ever repeated one or more grades? If so, which grade(s)? _____

Has this child ever been in special education, or received resource room help or tutoring?

When	Where	What kind?
_____	_____	_____
_____	_____	_____

Describe any current school problems:_____

_____

_____

Has this child ever received any developmental evaluations or testing in the past?

What type?	Where	What kind?
_____	_____	_____
_____	_____	_____

Briefly describe this child's attitude toward school:

_____

_____

_____

Other Information: Please list other items that you may feel are relevant to your child behavior?

_____

_____

NICHQ Vanderbilt Assessment Scale—PARENT Informant

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

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

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NICHQ Vanderbilt Assessment Scale—PARENT Informant

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

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

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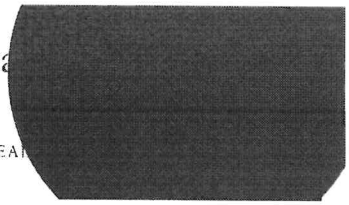

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D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.**

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

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D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant, continued

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____

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11-20/rev0303

Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this Form: _____ Date: _____

Name of Child: _____

		Please mark under the heading that best fits your child			For Office Use		
		NEVER	SOME-TIMES	OFTEN	I	A	E
1.	Fidgety, unable to sit still						
2.	Feels sad, unhappy						
3.	Daydreams too much						
4.	Refuses to share						
5.	Does not understand other people's feelings						
6.	Feels hopeless						
7.	Has trouble concentrating						
8.	Fights with other children						
9.	Is down on him or herself						
10.	Blames others for his or her troubles						
11.	Seems to be having less fun						
12.	Does not listen to rules						
13.	Acts as if driven by a motor						
14.	Teases others						
15.	Worries a lot						
16.	Takes things that do not belong to him or her						
17.	Distracted easily						
	(scoring totals)						

Scoring:

- Fill in unshaded box on right with: "Never" = 0, "Sometimes" = 1, "Often" = 2
- Sum the columns.
  PSC17 Internalizing score is sum of column I
  PSC17 Attention score is sum of column A
  PSC17 Externalizing score is sum of column E
  PSC-17 Total Score is sum of I, A, and E columns

Suggested Screen Cutoff:
PSC-17 - I ≥ 5
PSC-17 - A ≥ 7
PSC-17 - E ≥7
Total Score ≥ 15

Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.

Created by W Gardner and K Kelleher (1999), and based on PSC by M Jellinek et al. (1988)
Formatted by R Hilt, inspired by Columbus Children's Research Institute formatting of PSC-17

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Office use only: **Severity score:** _____

Johnson JG, Harris ES, Spitzer RL, Williams JB. The patient health questionnaire for adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolesc Health. 2002;30(3):196-204. doi:10.1016/s1054-139x(01)00333-0

asQ
Ask Suicide-Screening Questions

Ask the patient:

(1) In the past few weeks, have you wished you were dead? YES NO

(2) In the past few weeks, have you felt that you or your family would be better off if you were dead? YES NO

(3) In the past week, have you been having thoughts about killing yourself? YES NO

(4) Have you ever tried to kill yourself? YES NO

If yes, how? _____ When? _____

If the patient answers yes to any of the above, ask the following question:

(5) Are you having thoughts of killing yourself right now? YES NO

If yes, please describe: _____

Horowitz LM, Bridge JA, Teach SJ, et al. Ask Suicide-Screening Questions (ASQ): a brief instrument for the pediatric emergency department. Arch Pediatr Adolesc Med. 2012;166(12):1170-1176. doi:10.1001/archpediatrics.2012.1276

Provide resources to all patients: 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
24/7 Crisis Text Line: Text "HOME" to 741-741

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Silver Lake Pediatrics, P.A.

33017 Professional Dr
Leesburg, FL 34788
(352) 314-2275

ADD/ADHD – FOLLOW UP VISIT REQUIREMENTS:

1. Visits for medication follow-ups are scheduled separately and cannot be combined with any other type of visit. These visits are required in-person every 90 days. You are required to bring completed ADD/ADHD follow up forms (parent & teacher – available on our website). No refills can be done if the patient has exceeded 90 days.
2. It is suggested that only the parent(s) and the child be present for the follow up appointments. If it is necessary to bring siblings that are not old enough to wait in the reception area alone, arrangements should be made to bring another adult to watch them during the scheduled visit.
3. Refills for medication must be called in at least one week prior to your pickup date. These medications cannot be phoned into the pharmacy or mailed they must be picked up unless you enroll in our EPCS program. This program is $40 per year per child; this service allows us to send the prescription electronically to the pharmacy. This convenient service saves a monthly trip to our office.
4. If you should have any questions always feel free to contact our office at the number listed above.

I/We acknowledge the requirements listed above:

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Childs Name DOB