

FOLLOW UP FORM
Children's Habilitation Center, P.C.
Linda Nathanson-Lippitt, M.D.

Date_____

Patient Name_____DOB_____CA_____

Address:_____Address New?_____

Does your child have any allergies?_____

Send Copy of Report to (*treating physicians only-please share your copy w/ others*)

School Name_____Grade_____

Regular Ed_____ Special Ed_____Resource Program_____

Approximate # of teachers_____ Approximate # of students_____

Resource subjects_____

Date of last report card_____ Grades_____

Average time spent on homework_____

School modifications:

Special programs/therapy in school_____

Outside therapy_____

Extracurricular activities_____

| | Poor | | | Excellent | |
|---------------|------|---|---|-----------|---|
| Concentration | 1 | 2 | 3 | 4 | 5 |
| Impulsivity | 1 | 2 | 3 | 4 | 5 |
| Social Skills | 1 | 2 | 3 | 4 | 5 |

Time of day w/ particular difficulties_____am/pm

Adaptive equipment?_____

This section must be completed at each visit. DO NOT write "same" or "same as previous visit". List each accurately.

(*List accurate dosages ex: mg, mcg, tsp, tbl, etc.*)

Medications / Supplements / Over the Counter Meds Exact Dosage #of times per day

If child taking a stimulant medication, has child had baseline EKG? _____ If yes, when? _____

Special Diet? If yes, please describe.

Patient Name _____

Date _____

Interval Medical History/Symptoms:

(Please mark any of the following characteristics that apply to your child)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Poor school/work attending | <input type="checkbox"/> Worries | <input type="checkbox"/> Sadness | <input type="checkbox"/> Confused |
| <input type="checkbox"/> Mood changes | <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Staring Spells | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Problems w/ others | <input type="checkbox"/> Cruel | <input type="checkbox"/> Biting | <input type="checkbox"/> Destructive |
| <input type="checkbox"/> Trouble w/ teacher/boss | <input type="checkbox"/> Steals | <input type="checkbox"/> Disruptive | <input type="checkbox"/> Cheats |
| <input type="checkbox"/> Stomachaches | <input type="checkbox"/> Irritable | <input type="checkbox"/> Clumsy/Poor coordination | |
| <input type="checkbox"/> Aggressive toward others | <input type="checkbox"/> Headaches | <input type="checkbox"/> Problems Separating | |
| <input type="checkbox"/> Problems changing activities | <input type="checkbox"/> Wetting or soiling pants | <input type="checkbox"/> Poor response to discipline | |
| <input type="checkbox"/> Acts younger than his/her age | <input type="checkbox"/> Gets hurt frequently | <input type="checkbox"/> Doesn't listen to rules | |
| <input type="checkbox"/> Doesn't understand others feelings | <input type="checkbox"/> Fire setting | <input type="checkbox"/> Blames others | <input type="checkbox"/> Poor hygiene |
| <input type="checkbox"/> Gets teased | <input type="checkbox"/> Teases others | <input type="checkbox"/> Snoring | <input type="checkbox"/> Feels bad about self |
| <input type="checkbox"/> Problems falling to sleep | <input type="checkbox"/> Plays alone too much | <input type="checkbox"/> Facial twitching/tics | |
| <input type="checkbox"/> Sleep walking/talking | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Drowsiness | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> Other _____ | | | |

How is the family?

During the last 6 months, has your family experienced any of the following difficulties?

- | | |
|----------------------------|--|
| Death of a family member | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Serious illness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Marital problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Unemployment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Move | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcohol and/or Drug Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nervous/Emotional problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other _____ | |

Have any other family members had medical problems? Yes No
If yes, please describe _____

Any changes in who is living in your home? Yes No
If yes, please describe _____