



Welcome to

The Long Island Spectrum Center

Please take the time to go through the paperwork enclosed and complete it to the best of your ability. Your responses will help us to help you.

We want you to know that we truly care about your family and are committed to treating you as if you were members of our own family. Our ability to assess and intervene on your behalf is very much dependent on us developing a relationship based on communication. Please give us feedback on how we are doing. We believe that your input is an essential part of your child's treatment.

The Long Island Spectrum Center, Inc.

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www.lispectrum.com

PRENATAL HISTORY

Maternal age at delivery: _____ years

Illnesses during pregnancy:

Medication during pregnancy:

Other complications during pregnancy:

Complications during labor and delivery:

Mode of delivery: C-section/vaginal? If C-section, explain why:

If vaginal delivery, did you have forceps/vacuum?

Medication(s) during labor and delivery?

Full term/premature? (Circle one) How many weeks? _____ weeks

Complications after delivery?

Medications given to child during hospital stay?

Any maternal family history of autoimmune diseases?

EARLY DEVELOPMENT

Did baby come home on time?

Fussy/colicky?

Breast fed/Formula Fed?

Reflux/Spitting up?

Prone to ear/throat infections in first 2 years?

of rounds of antibiotics in first 24 months:

How was eye contact?

Developmental Milestones

When did your child:

Sit Up? _____

Roll Over? _____

Crawl? _____

Babble? _____

Walk? _____

Say 1st Word? _____

Did he/she crawl/move appropriately early on?

All Immunizations?

Any Reactions?

When did you first notice your child's problem?

What did you notice?

What is gradual or sudden onset?

Please make notation of any other event, action, etc. that you think may have some bearing/ relationship to your child's condition. Again, be as detailed as possible and do not hesitate to mention anything, no matter how small or insignificant, that you believe is related to your child's problem(s):

Did you get Early Intervention?

If so, what services and for how long?

Have you ever seen a DAN Doctors/Other Specialists?

List current therapy/educational programs?

What is your child's preferred activities?

PRESENT TIME

Are both parents present at home?

Do they startle easily? Gag easily?

Quality of home life?

Scripting/Repetitive Behaviors?

How much language does your child have?

How is their posture?

Are they Sensitive To: (describe)

Are they fascinated by spinning?

Light?

**Do they have self stimulatory behaviors?
(describe)**

Sound?

Touch?

Do they Eczema/Asthma/Allergies?

Can they stick their tongue out all the way?

How is their hearing/vision?

**Is their face symmetrical (even) on both sides?
(IE. One eye smaller than the other)**

Do they tilt their head when watching TV?

Any peculiar eye movements?

How is their fine motor control?

Any history of seizures?

How is their gross motor control?

Medications?

Run/Bike Ride?

Any particular diet?

How is their balance/motor planning?

**Do they POOP every day? Formed? Color?
Mucus?**

DIETARY/NUTRITIONAL HISTORY

Foods my child eats: (Place 3 in appropriate column)

Food					
	Daily	3 - 5 times/ week	1 - 3 times/ week	Never or almost never	Used to eat a lot but no longer does
Candy:					
Cookies:					
Caffeine (soda, tea, etc.):					
Chocolate:					
Milk: Whole:					
2 % :					
1 % :					
Skim:					
Cheese:					
Ice Cream:					
Salty Foods:					
Meat:					
Pasta:					
Bread: White:					
Wheat:					
Other:					

DIETARY/NUTRITIONAL HISTORY (Continued)

DAY 1

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

DAY 2

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

DAY 3

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

ENVIRONMENTAL HISTORY

CIRCLE THE APPROPRIATE ANSWERS TO THE FOLLOWING QUESTIONS:

Location of home: City/Suburban/Wooded/Farm Other (describe):

Water: City/well Purification system: Yes/No If yes, please describe:

Type of heat: Electric/gas/oil/other If other, please describe:

Do you live near: Power lines/woods/industrial areas/water?

If you live near water, list type: Swamp/river/ocean/other If other, please describe:

Does your home have a lot of: Dust/mold/down or feather items (pillows, upholstery, stuffed animals?)
If, so, please give details:

Describe your child's bedroom (Circle appropriate response):

Bedding: Synthetic/down/feather? Mattress cover: Yes/No Crib/Junior Bed/Adult Bed

Flooring: Carpet: Wall-to-wall or area rug? Wood? Glued down? Synthetic pad?

Window treatment: Shades/blinds/thin curtain/heavy curtain/valance/other? If other, describe:

Other items in room including furniture, toys, stuffed animals:

Flooring in other rooms:

Child's bathroom?

Living room?

Family room/play room?

Is your child sensitive to or bothered by any of the following?

Perfumes/cosmetics? Mold?

Cleaning products? Pollens/grasses?

Soaps? Animals (dander)?

Detergents? Gasoline?

Dust? Paint?

Other?

Please list known allergies:

SIGNS AND SYMPTOMS

Please check (1) any signs/symptoms your child may demonstrate and note duration and details if appropriate:

No.	Description	Mild	Moderate	Severe	Duration	Unique details
1	Mood swings					
2	Irritability/tantrums					
3	Fears/anxieties					
4	Difficulty falling to sleep					
5	Nail/hand/arm biting					
6	Hand/arm biting					
7	Recurrent/chronic fever					
8	Aggressiveness (hitting, kicking, biting others)					
9	Head banging					
10	Nightmares					
11	Bed wetting/soiling					
12	Hyperactivity					
13	Inability to concentrate/focus					
14	Always fidgety in his/her seat					
15	Impulsive					
16	Breath holding					
17	Dizziness					
18	Acute sense of smell					
19	Poor coordination					
20	Problems with buttons, ties, snaps or zippers					
21	Processing problems - visual, motor, language, etc.					
22	Problems with social interactions					
23	Sensitive to crowds					
24	Trouble remembering					
25	Low self-esteem					
26	Fatigue					
27	Cold hands/feet					
28	Cold intolerance					
29	Heat intolerance					

SIGNS AND SYMPTOMS (Continued)

Please check (1) any signs/symptoms your child may demonstrate and note duration and details if appropriate:

No.	Description	Mild	Moderate	Severe	Duration	Unique details
30	Stomach ache					
31	Skin flushing					
32	Difficulty waking					
33	Night waking					
34	Mucous/blood in stools					
35	Anal itching					
36	Toe walking					
37	Day time wetting/soiling					
38	Numbness/tingling in hands/feet					
39	Headache					
40	Blinking					
41	Tics					
41	Eye discharge					
43	Dark circles/puffiness under eyes					
44	Earaches					
45	Congestion					
46	Dripping nose					
47	Ridges/pitting of nails					
48	White spots/lines on nails					
49	Puts pressure on abdomen					
50	Any OCD (obsessive compulsive) behaviors					
51	Bad breath					
52	Nose bleeds					
53	Sore throats					
54	Hoarseness					
55	Cough					
56	Wheezing					

Please consider this question carefully.

If you could have ONE health wish for your child, what would it be?

Do you freely choose and desire the Long Island Spectrum Center's therapeutic approach for your child's medical condition(s) and understand that along with the significant benefits that can often be achieved there may always be, as with all treatments, some inherent risk? YES NO

To the best of my knowledge all of the above information is true and accurate.

Parent/Guardian

Signature: _____

For

Patient: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect August 31, 2006 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations.

For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider, providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your healthcare information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other to the extent necessary to help with your healthcare or with payment for healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition

**Acknowledgement of Receipt
of
Notice of Privacy Practices**

I, _____ acknowledge receiving the notice of Privacy Practices from the Long Island Spectrum Center.

Signature of Patient

Date

The LONG ISLAND SPECTRUM CENTER is a unique place, uniting educators, therapists and doctors to bring cutting edge programs to the NY Metro area. In doing so, your medical records and case may be viewed by employees and consultants of LONG ISLAND SPECTRUM CENTER in an attempt to deliver you the highest quality services.

Although we are an educational center, we contract with clinical personnel to provide therapy and interventions outside of the educational arena. There is a distinction between “therapies” (which are used to treat specific conditions) and “educational interventions” (which are used to create a better opportunity for learning). Our Functional Neurology and Biomedical services are examples of *therapies*. Our Educational Lab and SenEx Sensory Training Program are examples of *educational interventions*.

I understand that the SenEx Sensory Training Program does not claim to diagnose, cure, treat, prevent, or prescribe any physical, emotional, ophthalmic or optometric disorder. I further understand that the Sensory Training Program should be considered as only a sensory educational experience using visual colored light, modulated musical sound, vestibular exercise and vibration in an integrated process. I further understand that the Sensory Training Program is an adjunct to traditional therapeutic treatment approaches such as physical rehabilitation, psychology, speech or occupational therapy, and is not a substitute or replacement for osteopathic, optometric, medical, psychiatric, psychological, neurological and/or other medical services.

I understand that the LONG ISLAND SPECTRUM CENTER programs provide a unique learning experience, which may allow my child’s sensory systems to organize and improve processing abilities. I also understand that each person organizes his or her sensory systems differently and perceptions vary greatly from one person to the next. I understand and accept that although our programs provide the possibility of profound and gratifying changes, there is no guarantee that I will experience any change or improvement.

Since the LONG ISLAND SPECTRUM CENTER programs are unique, we are committed to teaching other professionals about our methods. To that end, we may be videotaping your consultations, examinations, therapies and educational programs during your time in our office. These tapes may be used in teaching and marketing capacities.

I hereby authorize the LONG ISLAND SPECTRUM CENTER staff/consultants to administer *therapies* and *educational interventions* as outlined in our report of findings to my son/daughter.

_____ please initial

Patient Agreement:

Please read and initial each paragraph below:

I will provide The LONG ISLAND SPECTRUM CENTER with current and accurate medical information as requested.

I will be on time or early for my scheduled appointments and respect that my time slot is exclusively allotted for my use.

I will promptly inform the doctor or Director of Education if I am experiencing any discomfort during or after the sessions.

If I am currently under treatment for any medical condition, I will have my treating physician or other treating health care professional monitor my condition during the time I participate in the Sensory Training Program.

I accept the terms and conditions of the Financial Agreement, separately signed by me, and incorporated into this Patient Agreement.

I authorize release of medical information to our healthcare providers listed herein.

I have read and understand the above consents and requirements for participation in The LONG ISLAND SPECTRUM CENTER programs.

Patient Name _____

Patient Signature _____

Date _____

Legal Guardian Name _____

Guardian Signature _____

Date _____