



## Associated Neurologists, P.C.

69 Sand Pit Road, Suite 300 · Danbury, Connecticut 06810 · Tel: (203) 748-2551 · Fax: (203) 790-6375  
1389 W. Main Street, Suite 212 · Waterbury, Connecticut 06708 · Tel: (203) 755-7367 · Fax: (203) 755-1947

### Adult Neurology

Jan Mashman, M.D.  
Martin Kremenitzer, M.D.  
Diane Wirz, M.D.  
Samuel Markind, M.D.  
Neil Culligan, M.D.  
Anna Alshansky, M.D.  
David Greco, M.D.  
Robert Bonwetsch, M.D.  
Maria Sangiorgio, M.D.  
Behzad Habibi, M.D.  
Joan Ellen Gereg, APRN  
Loralee Richter, PA-C  
Melisa Pelikan, RN  
Dawn Murphy, RN

**PLEASE CHECK WITH YOUR INSURANCE COMPANY  
TO SEE IF A REFERRAL IS REQUIRED PRIOR TO YOUR  
SCHEDULED APPOINTMENT.**

**THANK YOU**

### Pediatric Neurology

Martin Kremenitzer, M.D.  
Anna Alshansky, M.D.

### Neuropsychology

Stephen Peters, Psy.D., ABN  
Michelle Bobulinski, Ph.D.  
Erin Lasher, Psy.D.

### Neurophysiology

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### Clinical Studies

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Cynthia Bahr, P.T.  
Beth Capron, MPT  
Karen Nell, PTA  
Nicole Saviano, PTA  
Diane Yandow, P.T.

### Administration

Arlene Barra  
Wendy White

## **Directions to Associated Neurologists Danbury Office**

**69 Sand Pit Road, Suite 300  
Danbury, CT 06810  
203-748-2551**

Route 84 (East or West) to EXIT 7

Take the next EXIT ( Exit 11, Federal Rd )

Make right at light (White Turkey Extn) Take this to the end ( Approx 1 mile )

Make left at light ( This is Federal Rd )

Go to 2nd light make right (just past the rte 84 overpass - sign points right to Germantown)

### **From Hartford - 84 Heading West**

1. Take exit 7 (Brookfield, New Milford, North) and stay in the right lane.
2. Take the first exit onto Federal Road.
3. At the end of the ramp, turn right. Follow this connector road to the end.
4. Turn left at the light onto Federal Road and stay in the right lane.
5. You will pass a Harley Davidson dealership on the left.
6. At the 2nd light, turn right onto Starr Road (just beyond the underpass).
7. At the traffic light, turn right onto Sand Pit Road.
8. You will pass the AT&T garage on the right.
9. Look for the sign "Medical Center of Western Connecticut" on the left.
10. Turn left into that driveway and drive straight ahead to building 69 (the brick building with the green roof).

### **From New York State - 84 Heading East**

1. Take exit 7 (Brookfield, New Milford, North). This will be a left lane exit.
2. Take the first exit onto Federal Road.
3. At the end of the ramp, turn right. Follow this connector road to the end.
4. Turn left at the light onto Federal Road and stay in the right lane.
5. You will pass a Harley Davidson dealership on the left.
6. At the 2nd light, turn right onto Starr Road (just beyond the underpass).
7. At the traffic light, turn right onto Sand Pit Road.
8. You will pass the AT&T garage on the right.
9. Look for the sign "Medical Center of Western Connecticut" on the left.
10. Turn left into that driveway and drive straight ahead to building 69 (the brick building with the green roof).

## **Route 7 North - From Ridgefield and South**

1. Travel north on Route 7 and merge onto 84 towards Hartford. Stay in left lane. Follow directions as if from New York State – 84 Heading East.

## **Route 7 South - From New Milford and North**

1. Travel south on Route 7 and take left onto Route 7 spur.
2. Take the second exit onto Federal Road.
3. At the end of the ramp, turn left. Follow this connector road to the end.
4. Turn left at the light onto Federal Road and stay in the right lane.
5. You will pass a Harley Davidson dealership on the left.
6. At the 2nd light, turn right onto Starr Road (just beyond the underpass).
7. At the traffic light, turn right onto Sand Pit Road.
8. You will pass the AT&T garage on the right.
9. Look for the sign "Medical Center of Western Connecticut" on the left.
10. Turn left into that driveway and drive straight ahead to building 69 (the brick building with the green roof).

***Directions to Associated Neurologists Waterbury Office  
1389 W. Main Street Suite 212  
Waterbury, CT 06708  
203-755-7367***

**Traveling West on 84 from Hartford/Waterbury:**

- Take I-84 to exit 18 – Chase Parkway
- Bear left
- Turn left at the light at the end of the ramp
- 1389 W. Main Street is the large white medical building on the left (Waterbury Medical Center)
- We are in Tower 1, Suite 212 (look for “Associated Neurologists” on the directory by the elevator)

**Traveling East from New York/Danbury/Newtown:**

- Take I-84 to exit 18 – Chase Parkway
- At the end of the ramp, turn right
- Turn right at the light
- Turn right at the next light onto W. Main Street
- 1389 West Main Street is the large white building (Waterbury Medical Center)
- We are in Tower 1, Suite 212 (look for “Associated Neurologists” on the directory by the elevator)

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

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_



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David Greco, M.D.  
Loralee Richter, PA-C

Referring Physician: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Your Age: \_\_\_\_\_

Chief Complaint (Why were you referred to Associated Neurologists)? \_\_\_\_\_

### HPI (History of Present Illness)

<input type="checkbox"/> Location	
<input type="checkbox"/> Quality	
<input type="checkbox"/> Severity	
<input type="checkbox"/> Duration	
<input type="checkbox"/> Timing	
<input type="checkbox"/> Context	
<input type="checkbox"/> Modifying Factors	
<input type="checkbox"/> Assoc. Signs/ Symptoms	

### PMH (Past Medical History)

<b>Document Prior:</b>	
<input type="checkbox"/> Major Illnesses	
<input type="checkbox"/> Operations	
<input type="checkbox"/> Hospitalizations	

Medications (List all medications you are currently taking)	Drug	Dose (mg)	Frequency

Medication Allergies: \_\_\_\_\_ Please state "none" if no allergies to medications

**Please see other side**

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

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Social History:**

Marital Status:  Married  Single  Divorced  Widow(er) Alcohol:  No  Yes Amount: \_\_\_\_\_

Education: \_\_\_\_\_ Tobacco:  No  Yes Amount: \_\_\_\_\_

Occupation: \_\_\_\_\_

Other Information: \_\_\_\_\_

**Family History:**

	Age (Currently or at death)	State of Health (Indicate if deceased)	Significant Disease or Illnesses (If deceased, indicate cause of death)
Mother			
Father			
Brothers			
Sisters			
Children			

**REVIEW OF SYSTEMS**  
Please check all that apply

- 1. Constitutional**  Negative  
 Feeling tired or poorly  
 Fever  
 Recent change in weight

- 5. Respiratory**  Negative  
 Cough  
 Wheezing  
 Difficulty swallowing

- 9. Integumentary (Skin)**  Negative  
 Itching  
 Unusual growth on skin

- 2. Eyes**  Negative  
 Loss of part of field of vision  
 White/light spots in field of vision  
 Seeing double images  
 Blurry vision

- 6. Gastrointestinal**  Negative  
 Nausea  
 Vomiting  
 Change in the stool  
 Diarrhea  
 Constipation

- 10. Neurological**  Negative  
 Headache  
 Numbness  
 Tingling  
 Difficulty walking

- 3. Ears, Nose, Mouth Throat**  Negative  
 Loss of hearing  
 Earache  
 Discharge from the ears  
 Nosebleeds  
 Choking

- 7. Genitourinary**  Negative  
 Burning sensation during urination  
 Urinary loss of control  
 Urinary frequency  
 Blood in urine

- 11. Psychiatric**  Negative  
 Depression  
 Anxiety  
 Unreasonable or irrational fears

- 4. Cardiovascular**  Negative  
 Chest pain or discomfort  
 Palpitations  
 Difficulty breathing  
 Shortness of breath

- 8. Musculoskeletal**  Negative  
 Joint pains  
 Bone pain  
 Lower back pain  
 Neck pain

- 12. Endocrine**  Negative  
 Excessive thirst/fluid intake  
 Temperature intolerance to heat  
 Temperature intolerance to cold

- 13. Hematological / Lymph**  Negative  
 Easy bruising  
 Easy bleeding

Please print clearly and complete all items

Associated Neurologists, P.C. 69 Sand Pit Road Danbury, CT 06810 (203) 748-2551

\*\*Appt. Confirmation Phone Number \_\_\_\_\_\*\*

Pharmacy \_\_\_\_\_ Location: \_\_\_\_\_  
E-mail address \_\_\_\_\_

Patient First Name: \_\_\_\_\_ MI \_\_\_\_\_

Patient's Home Phone # ( ) \_\_\_\_\_

Patient Last Name: \_\_\_\_\_

Patient's Work Phone # ( ) \_\_\_\_\_

Street Address: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

City: \_\_\_\_\_

Patient Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female

State, Zip Code: \_\_\_\_\_

Patient Social Security Number \_\_\_\_\_

Marital Status (please circle) (child) S M D W

Dominant Hand: \_\_\_\_\_ Left \_\_\_\_\_ Right \_\_\_\_\_ Both

Primary Care Physician \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Care Physician phone # \_\_\_\_\_

Referring Physician Phone #: \_\_\_\_\_

Maiden Name (if applicable) \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Phone # \_\_\_\_\_

Employer Address: \_\_\_\_\_

Is this MVA? If so Date of Accident \_\_\_\_\_

Spouse Name: \_\_\_\_\_

Is this Work Comp.? If so Date of Injury \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Reason you are here: \_\_\_\_\_

**Insurance Information**

**Primary Insurance Information:** \_\_\_\_\_ relationship to patient: \_\_\_\_\_

Insurance Company Name and Address: \_\_\_\_\_

Policy ID #: \_\_\_\_\_

Group Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Holder Social Security # : \_\_\_\_\_

Policy Holder Address: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_

Employer Phone Number: \_\_\_\_\_

**Secondary Insurance Information:** \_\_\_\_\_ relationship to patient: \_\_\_\_\_

Insurance Company Name and Address: \_\_\_\_\_

Policy ID #: \_\_\_\_\_

Group Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Holder Social Security # \_\_\_\_\_

Policy Holder Address: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_

Employer Phone Number: \_\_\_\_\_

**Financial and Privacy Policy and Permission to Treat (Please read carefully)**

Charges for medical services are due and payable by the patient / guardian at the time services are rendered. Co-payments, deductibles, and coinsurance are due at the time of service for Medicare and other Health Care Plans that are accepted by this office. Obtaining proper referrals to this practice is the patient / guardian's responsibility and if proper referrals are not obtained, the patient / guardian is responsible for payment in full for professional services rendered. Charges for patients with insurance plans we do not participate with are due and payable in full at time of service. The patient / guardian is responsible for all fees, regardless of insurance coverage. Motor Vehicle and Liability claims are the patient / guardian's responsibility. If the patient misses an appointment, a missed appointment fee of \$50.00 will be charged. Finance charges will accrue on balances that are over thirty days. The patient / guardian is liable for all collection costs (collection agency fees, legal fee, and court cost) in addition to professional fees charged by this practice. Checks returned by the bank will incur an additional \$25.00 service fee. I have read the above and request that all payments by my insurance carrier, including Medicare, to be paid directly to Associated Neurologists, P.C. I also authorize the release of any medical or other information to my insurance carrier necessary to process my claims. **The signature below acknowledges that I have received a copy of Associated Neurologist's Privacy Policy. I have read and understand its contents and agree to abide by the terms and conditions therein.**

Signature of patient / guardian \_\_\_\_\_ Date: \_\_\_\_\_



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### Administration

Arlene Barra  
Wendy White

### **Financial Policy**

We are dedicated to providing you with the best possible care and service. It is essential that you have a clear understanding of your financial responsibilities. Unless you or your health insurance carriers have made other arrangements in advance, full payment is due at the time of service. For your convenience, we accept MasterCard, Visa, and Discover.

### **Your Appointment:**

If you are late for your appointment, please be aware that you may be asked to reschedule that appointment in an effort to prevent delaying other patients who have arrived on time.

### **Insurance Coverage:**

We have agreements with many insurance plans (including Medicare) to accept their fee schedules. We will submit claims on your behalf to the insurance carriers with whom we participate. Please make sure you check with your insurance carrier to see if we are on your insurance plan as a participating provider. You are required to pay the co-pay on the same day you receive our services. It is your responsibility to know your individual benefits and the limits on your health insurance plan. In the event your health plan determines that a service is "not covered," you will be responsible for the entire charge, and payment is due upon receipt of our billing statement. If we do not participate with your insurance plan, you are responsible for payment in full on the day the service is rendered. You are also responsible for notifying our office whenever your insurance plan changes.

### **Motor Vehicle, Workers' Compensation, and Liability Services:**

As a courtesy, we will bill your motor (MVA) or liability insurance carrier. Should your policy exhaust (meaning your coverage has been fully used), you are responsible for any balance due, which is payable upon receipt of our billing statement. Accidents involving litigation do not absolve you from your financial responsibility to Associated Neurologists, P.C. You are responsible for full payment for our services - due upon receipt of our billing statement. You are to collect any settlement monies from your attorney. We will bill your Workers' Compensation carrier as required by law; however, any Workers' Compensation case that is contested by your employer and subsequently denied is your financial responsibility.

**Referrals:**

It is your responsibility to make sure that all referrals from your primary care physician are in place prior to your scheduled visit. Failure to have proper referrals will result in your being responsible for full payment of services on the day of your appointment; otherwise, your appointment will be cancelled.

**Missed Appointments:**

We reserve the right to charge you a missed appointment fee of \$50.00 when appointments are not cancelled at least 24 hours in advance. This charge is not billable to your insurance carrier and is your responsibility. When you do not keep your appointment, you hold a valuable spot for another patient who requires medical care. **Your consideration by arriving on time for your scheduled appointment is essential to all patient care.**

**Minor Patients:**

A parent or custodial guardian must accompany any patient under the age of 18 years, and any payment due is the responsibility of that parent or guardian on the day of service.

**Returned Checks:**

If you pay us with a personal check and your bank returns that check to us, you will be charged a \$25.00 service fee. You are then required to remit all monies due by either a money order or a certified bank check.

**Delinquent Accounts:**

Payment is due upon receipt of our billing statement. Accounts that are past due will accumulate finance charges equal to 1.5% per month (with a minimum of \$1.00/month). Accounts that are over 90 days past due may be sent to a collection agency, small-claims court, or our attorney. Patients / guardians who are sent to a collection agency or court will be responsible for collection agency fees, court costs, and legal fees in addition to the original outstanding balance due.

**Insurance Authorization and Financial Policy Agreement:**

I hereby authorize Associated Neurologists, P.C. to furnish information to my insurance carrier concerning my illness and treatment necessary to process my claims. I acknowledge that I have received a copy of Associated Neurologists' Financial and Privacy Policy.

I have read and understand the financial policy of this practice, and I agree to be bound by its terms and conditions therein. I also understand and agree that such terms may be amended from time to time by the Practice.

\_\_\_\_\_  
Signature of patient or parent / legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print the name of the person signing

\_\_\_\_\_  
Please print the name of the patient

\_\_\_\_\_  
Account # (completed by staff)

# CHILD SYMPTOM INVENTORY- 4: TEACHER CHECKLIST

*Please return checklist to the office prior to your appointment*

<b>CHILD'S NAME</b>	<b>AGE</b>	<b>GENDER</b>
<b>SCHOOL</b>	<b>GRADE</b>	<b>DATE</b>

NAME OF PERSON COMPLETING THIS FORM \_\_\_\_\_ POSITION \_\_\_\_\_

LENGTH OF TIME YOU HAVE KNOWN STUDENT \_\_\_\_\_ LENGTH OF TIME EACH DAY WITH STUDENT \_\_\_\_\_

TYPE OF CLASS (EG. REGULAR 2<sup>ND</sup> GRADE, RESOURCE ROOM, 6<sup>TH</sup> GRADE ENGLISH): \_\_\_\_\_

CURRENT SPECIAL EDUCATION SERVICES (E.G., RESOURCE ROOM, SPEECH THERAPY): \_\_\_\_\_

CURRENT SPECIAL EDUCATION LABEL (E.G., LEARNING DISABILITY): \_\_\_\_\_

CURRENT ACADEMIC PERFORMANCE: CHECK APPROPRIATE GRADE LEVEL (G.L.)

SUBJECT	2 OR MORE YRS BELOW G.L.	1 TO 2 YEARS BELOW G.L.	AT OR ABOUT G.L.	1 TO 2 YEARS ABOVE G.L.	2 OR MORE YEARS ABOVE G.L.
READING					
WRITING					
SPELLING					
ARITHMETIC					

**DIRECTIONS: CHECK WHICH RATING BEST DESCRIBES THIS CHILD'S OVERALL BEHAVIOR IN OR AROUND SCHOOL. ANSWER EACH QUESTION TO THE BEST OF YOUR ABILITY.**

## CATEGORY A

	NEVER	SOME-TIMES	OFTEN	VERY OFTEN
1. FAILS TO GIVE CLOSE ATTENTION TO DETAILS OR MAKES CARELESS MISTAKES				
2. HAS DIFFICULTY PAYING ATTENTION TO TASKS OR PLAY ACTIVITIES				
3. DOES NOT SEEM TO LISTEN WHEN SPOKEN TO DIRECTLY				
4. HAS DIFFICULTY FOLLOWING THROUGH ON INSTRUCTIONS AND FAILS TO FINISH THINGS				
5. HAS DIFFICULTY ORGANIZING TASKS AND ACTIVITIES				
6. AVOIDS DOING TASKS THAT REQUIRE A LOT OF MENTAL EFFORT (SCHOOLWORK, HOMEWORK, ETC.)				
7. LOSES THINGS NECESSARY FOR ACTIVITIES				
8. IS EASILY DISTRACTED BY OTHER THINGS GOING ON				
9. IS FORGETFUL IN DAILY ACTIVITIES				

**CATEGORY A**

	NEVER	SOME-TIMES	OFTEN	VERY OFTEN
10. FIDGETS WITH HANDS OR FEET OR SQUIRMS IN SEAT				
11. HAS DIFFICULTY REMAINING SEATED WHEN ASKED TO DO SO				
12. RUNS ABOUT OR CLIMBS ON THINGS WHEN ASKED NOT TO DO SO				
13. HAS DIFFICULTY PLAYING QUIETLY				
14. IS "ON THE GO" OR ACTS AS IF "DRIVEN BY A MOTOR"				
15. TALKS EXCESSIVELY				
16. BLURTS OUT ANSWERS TO QUESTIONS BEFORE THEY HAVE BEEN COMPLETED				
17. HAS DIFFICULTY AWAITING TURN IN GROUP ACTIVITIES				
18. INTERRUPTS PEOPLE OR BUTTS INTO OTHER CHILDREN'S ACTIVITIES				

**CATEGORY B**

19. LOSES TEMPER				
20. ARGUES WITH ADULTS				
21. DEFIES OR REFUSES WHAT YOU TELL HIM/HER TO DO				
22. DOES THINGS TO DELIBERATELY ANNOY OTHERS				
23. BLAMES OTHERS FOR OWN MISBEHAVIOR OR MISTAKES				
24. IS TOUCHY OR EASILY ANNOYED BY OTHERS				
25. IS ANGRY AND RESENTFUL				
26. TAKES ANGER OUT ON OTHERS OR TRIES TO GET EVEN				

**CATEGORY C**

27. PLAYS HOOKEY FROM SCHOOL				
29. LIES TO GET THINGS OR TO AVOID RESPONSIBILITY ("CONS OTHERS")				
30. BULLIES, THREATENS, OR INTIMIDATES OTHERS				
31. STARTS PHYSICAL FIGHTS				
33. HAS STOLEN THINGS WHEN OTHERS WERE NOT LOOKING				
34. HAS DELIBERATELY DESTROYED OTHER'				
36. HAS STOLEN THINGS FROM OTHERS USING PHYSICAL FORCE				
38. HAS USED A WEAPON WHEN FIGHTING (BAT, BRICK, BOTTLE, ETC.)				
40. HAS BEEN PHYSICALLY CRUEL TO PEOPLE				

**CATEGORY D**

42. IS OVERCONCERNED ABOUT ABILITIES IN ACADEMIC, ATHLETIC, OR SOCIAL ACTIVITIES				
43. HAS DIFFICULTY CONTROLLING WORRIES				
44. ACTS RESTLESS OR EDGY				
45. IS IRRITABLE FOR MOST OF THE DAY				
46. IS EXTREMELY TENSE OR UNABLE TO RELAX				

**CATEGORY E**

	NEVER	SOME-TIMES	OFTEN	VERY OFTEN
49. SHOWS EXCESSIVE FEAR TO SPECIFIC OBJECTS OR SITUATIONS (ANIMALS, HEIGHTS, STORMS, INSECTS, ETC.)				
50. CANNOT GET DISTRESSING THOUGHTS OUT OF HIS/HER MIND (WORRIES ABOUT GERMS OR DOING THINGS PERFECTLY, ETC.)				
51. FEELS COMPELLED TO PERFORM UNUSUAL HABITS (HAND WASHING, CHECKING LOCKS, REPEATING THINGS IN A SET NUMBER OF TIMES)				
52. HAS EXPERIENCED AN EXTREMELY UPSETTING EVENT AND CONTINUES TO BE BOTHERED BY IT				
53. DOES UNUSUAL MOVEMENTS FOR NO APPARENT REASON (EYE BLINKING, TWITCHING, LIP LICKING, HEAD JERKING, ETC.)				
54. MAKES VOCAL SOUNDS FOR NO APPARENT REASON (COUGHING, THROAT CLEARING, SNIFFLING, GRUNTING, ETC.)				

**CATEGORY F**

55. HAS STRANGE IDEAS OR BELIEFS THAT ARE NOT REAL (CHILD'S FOOD IS POISONED, PEOPLE ARE TRYING TO GET HIM/HER, ETC.)				
56. HAS AUDITORY HALLUCINATIONS—HEARS VOICES TALKING TO OR TELLING HIM/HER TO DO THINGS				
57. HAS EXTREMELY STRANGE AND ILLOGICAL THOUGHTS OR IDEAS				
58. LAUGHS OR CRIES AT INAPPROPRIATE TIMES OR SHOWS NO EMOTION IN SITUATIONS WHERE MOST OTHERS OF SAME AGE WOULD REACT				
59. DOES EXTREMELY ODD THINGS (EXCESSIVE PREOCCUPATION WITH FANTASY FRIENDS, TALKS TO SELF IN A STRANGE WAY, ETC.)				

**CATEGORY G**

60. IS DEPRESSED FOR MOST OF THE DAY				
61. SHOWS LITTLE INTEREST IN (OR ENJOYMENT OF) PLEASURABLE ACTIVITIES				
62. HAS RECURRENT THOUGHTS OF DEATH OR SUICIDE				
63. FEELS WORTHLESS OR GUILTY				
64. HAS LOW ENERGY LEVEL OR IS TIRED FOR NO APPARENT REASON				
65. HAS LITTLE CONFIDENCE OR IS VERY SELF CONSCIOUS				
66. FEELS THAT THINGS NEVER WORK OUT RIGHT				
69. HAS EXPERIENCED A BIG CHANGE IN HIS/HER NORMAL ACTIVITY LEVEL (CIRCLE YES OR NO)		<b>NO</b>		<b>YES</b>
70. HAS EXPERIENCED A BIG CHANGE IN HIS/HER ABILITY TO CONCENTRATE (CIRCLE YES OR NO)		<b>NO</b>		<b>YES</b>
71. HAS EXPERIENCED A BIG DROP IN SCHOOL GRADES OR SCHOOLWORK (CIRCLE YES OR NO)		<b>NO</b>		<b>YES</b>



## Children (3 to 6 Years Old) Parent Form

*Please return form to the office prior to your appointment*

Child's Name	Gender	Date of Birth	Age
Name of Person Completing Form	Relationship To Child		Date

Is child attending a Day Care, Preschool, or Kindergarten program? (Please Circle)?    Yes    No

If Yes, what type of program? \_\_\_\_\_

Is child receiving Special Education services? (Please Circle)    Yes    No

If Yes, what Special Education services? (Speech Therapy, Physical Therapy, Counseling, etc.):

\_\_\_\_\_

Do you have concerns about your child's behavior? (if Yes, please specify) \_\_\_\_\_

\_\_\_\_\_

Have you ever sought help for these problems? (If Yes, please specify) \_\_\_\_\_

\_\_\_\_\_

If child is currently taking medication for behavior problems, please specify name: \_\_\_\_\_

Directions: Compared with other children who are the same age, how often does this child:

	Never	Some-times	Often	Very Often
1. Use words to communicate his or her needs				
2. Understand what other people say to him/her				
3. Have conversations with you about events or activities				
4. Pronounce words in a way that other people can understand				
5. Seem clumsy or poorly coordinated				
6. Have difficulty with hand coordination such as using scissors, crayons, or blocks, or manipulating small objects				
7. Have difficulty taking care of self (washing, eating, dressing, toileting)				
8. Enjoy make believe play with other children				
9. Enjoy make believe play by himself/herself				
10. Play with other children the same age				
11. Seek comfort when hurt				
12. Want to please adults				

**DIRECTIONS:** Check which rating best describes this child's overall behavior. Answer each question to the best of your ability.

**Category A: Compared with Other Children the Same Age**

	NEVER	SOME-TIMES	OFTEN	VERY OFTEN
1. Rushes through tasks or activities paying little attention to details.				
2. Has difficulty paying attention to tasks or play activities (looking at picture books, etc.)				
3. Does not seem to listen when spoken to directly				
4. Shifts from one uncompleted activity to another				
5. Has difficulty organizing tasks and activities				
6. Avoids doing tasks that require mental effort (puzzles, art projects, etc.)				
7. Loses things necessary for activities				
8. Is easily distracted by other things going on				
9. Is forgetful in daily activities				
10. Fidgets with hands or feet or squirms in seat				
11. Has difficulty remaining seated when asked to do so				
12. Runs about or climbs on things when asked not to do so				
13. Has difficulty playing quietly				
14. Is "on the go" or acts as if "driven by a motor"				
15. Talks excessively				
16. Blurts out answers to questions before they have been completed				
17. Has difficulty awaiting turn in group activities				
18. Interrupts people or disrupts other children's activities				
19. When asked to change an activity, has difficulty attending to new task				
20. Daydreams, acts spaced out				

**CATEGORY B: Compared with other Children the Same Age**

21. Loses temper				
22. Argues with adults				
23. Defies or refuses what you tell him/her to do				
24. Does things to deliberately annoy others				
25. Blames others for own misbehaviors or mistakes				
26. Is touchy or easily annoyed by others				
27. Is angry and resentful				
28. Takes anger out on others or tries to get even				

**CATEGORY C: Compared with Other Children the Same Age**

	NEVER	SOME-TIMES	OFTEN	VERY OFTEN
29. Does serious lying				
30. Bullies, threatens, or intimidates others				
31. Starts physical fights				
32. Steals things				
33. Deliberately destroys others' property				
34. Deliberately starts fires				
35. Uses a weapon when fighting (scissors, rock, stick, etc.)				
36. Is physically cruel to animals				
37. Is physically cruel to people				
38. Is preoccupied with or involved in sexual activity				

**PCS: Compared with Other Children the Same Age**

39. Grabs things from other children				
40. Throws things at other children				
41. Smashes or destroys things				
42. Gives dirty looks or makes threatening gestures to other children				
43. Curses at or teases other children to provoke conflict				
44. Damages other children's property				
45. Hits, pushes, or trips other children				
46. Threatens to hurt other children				
47. Engages in physical fights with other children				
48. Annoys other children to provoke them				

**CATEGORY D**

49. Gets very upset when child expects to be separated from home or parents				
50. Worries that parents will be hurt or leave home and not come back				
51. Worries that some disaster (getting lost, kidnapped, etc.) will separate child from parents				
52. Tries to avoid going to school in order to stay home with parent				
53. Worries about being left at home alone or with a sitter				
54. Afraid to go to sleep unless near parent				
55. Has nightmares about being separated from parent				
56. Complains about feeling sick when child expects to be separated from home or parents				

**CATEGORY E: Compared with other Children the Same Age**

	NEVER	SOME-TIMES	OFTEN	VERY OFTEN
57. Is overly fearful of (or tries to avoid) specific objects or situations				
58. Cannot get distressing thoughts out of his/her mind (worries about germs or doing things perfectly)				
59. Feels compelled to perform unusual habits (line up toys in a particular way, etc.) or do things in a set or rigid way				
60. Does unusual movements for no apparent reason (eye blinking, twitching, lip licking, head jerking, etc.)				
61. Makes vocal sounds for no apparent reason (coughing, throat clearing, sniffing, grunting, etc.)				
62. Worries that other children can do things better than he/she can				
63. Worries more than other children				
64. Complains about physical problems (aches and pains, upset stomach, etc.) for which there is no apparent cause				
65. Refuses to speak other than to family members				

**CATEGORY F: Compared with other Children the Same Age**

66. Is sad for most of the day				
67. Is irritable for most of the day				
68. Shows little interest in fun activities or playing with other children				
69. Talks about death or suicide				
70. Feels bad about self (e.g., says he/she is a bad child)				
71. Has low energy level or is tired for no apparent reason				

**Circle YES or NO**

72. Has experienced a change in his/her normal appetite or weight	NO	YES
73. Has experienced a change in his/her normal sleeping habits-trouble sleeping or sleeps too much	NO	YES
73. Has experienced a change in his/her normal activity level-overactive or inactive	NO	YES
75. Has experienced a change in his/her ability to concentrate or make decisions	NO	YES
76. Has become more sensitive or tearful than usual	NO	YES
77. Has experienced a very stressful event such as parents divorce, death of a friend or relative, serious illness	NO	YES

**CATEGORY G: Compared with Other Children the Same Age**

	NEVER	SOME-TIMES	OFTEN	VERY OFTEN
78. Is excessively shy with peers				
79. Is generally warm and outgoing with family members and familiar adults				
80. When put in an uncomfortable social situation, child cries, freezes, or withdraws from interacting				

**CATEGORY H**

81. Has trouble falling asleep				
82. Wakes up crying in the middle of the night				
83. Wakes up much earlier than usual				
84. Crawls into parents bed in the middle of the night				

**CATEGORY I**

85. Wets bed at night				
86. Wets bed at night now but was dry at night for at least four months				
87. Wets underwear during daytime hours				
88. Soils underwear during daytime hours				

**CATEGORY J: Compared with Other Children the Same Age**

89. Has experienced an extremely upsetting event and continues to be bothered by it				
90. Has distressing dreams or memories about an extremely upsetting event				
91. Repeatedly talks about or acts out in play an extremely upsetting event				
92. Seems like he/she is in a trance				

**CATEGORY K**

93. Refuses to eat enough food to maintain a healthy body weight				
94. Has extremely rigid eating habits (e.g., won't eat solid food, only eats baby food)				

**CATEGORY L: Compared with Other Children the Same Age**

95. Seems to be afraid or distrustful, even with familiar people (avoids contact or comforting, watches from sidelines)				
96. Seeks affection from most adults, even strangers				



# Developmental/ADHD Questionnaire

**Important: Please mail/fax this completed form to the office prior to your appointment**

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Mother \_\_\_\_\_ Age \_\_\_\_\_

Mother's Education \_\_\_\_\_ Current Employment \_\_\_\_\_

Name of Father \_\_\_\_\_ Age \_\_\_\_\_

Father's Education \_\_\_\_\_ Current Employment \_\_\_\_\_

Parents' marital status: Married Separated Divorced Remarried

Siblings and their ages \_\_\_\_\_

## **A. Pre and Perinatal History**

Did mother take any of the following during pregnancy?

Beer Wine Hard liquor Cigarettes Medications (list below)

\_\_\_\_\_

Were there any medical problems during pregnancy? \_\_\_\_\_

\_\_\_\_\_

Was there any fetal distress during labor? \_\_\_\_\_

Delivery: Normal Induced Forceps Caesarian Breech

What was the estimated due date? \_\_\_\_\_ Birth weight \_\_\_\_\_

Were there any post natal medical problems? \_\_\_\_\_

\_\_\_\_\_

## **B Infancy**

Were there any of these early problems?

Poor feeding Vomiting Colic Excessive Sleepiness Poor Sleep

Was (s)he a difficult baby? \_\_\_\_\_

How would you rate your child's activity level as a toddler?

Very active Active Average Less active Very inactive

What age were these developmental milestones achieved?

Walked \_\_\_\_\_ Spoke first word (other than "mama" and "dada") \_\_\_\_\_

Strung two or more words together \_\_\_\_\_

Did you have any concerns about his/her development? \_\_\_\_\_

Name of Child \_\_\_\_\_

**Educational History**

Please list any preschools attended, approximate dates, and any special services received (e.g., speech or occupational therapy):

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Please list schools attended, grade level, and what kind of modified instruction was received (e.g., home tutor; resource room; self contained classroom; adaptive phys. Ed.; speech, occupational, or physical therapy; counseling or psychotherapy provided by school)

School	Grades	Modified instruction
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever received psychological testing, either privately or by the school district? Yes/No. If so, please obtain the results of these tests. Please summarize in your own words the results of this testing and the recommendations that were made to you.

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Name of Child \_\_\_\_\_

Has your child had any of the following prior evaluations and/or interventions?  
(Please check all that apply)

Child Neurology \_\_\_\_\_ Child Psychiatry \_\_\_\_\_

Psychotherapy \_\_\_\_\_ Medications \_\_\_\_\_

**Past Medical History**

Hospitalization: \_\_\_\_\_

Surgery: \_\_\_\_\_

Medications: \_\_\_\_\_

Medication Allergy: \_\_\_\_\_

- Otitis Media
- Headaches
- Seizures
- Head Injury
- Enuresis
- Encopresis
- Fractures
- Lead intoxication
- Hearing loss
- Visual impairment
- Strabismus
- Asthma
- UTI

**Family History**

Significant for (Circle and list affected members):

- |                           |                                   |
|---------------------------|-----------------------------------|
| ADHD                      | Hearing Loss                      |
| Learning Disability       | Visual Loss                       |
| Speech Delay              | Tourette's Syndrome/tic disorders |
| Mental Retardation        | Depression                        |
| Autism/PDD                | Bipolar disorder                  |
| Seizures                  | Obsessive-Compulsive Disorder     |
| Cerebral Palsy            | Consanguinity                     |
| Alcohol / substance abuse | Other                             |



## Associated Neurologists, P.C.

69 Sand Pit Road, Suite 300 · Danbury, Connecticut 06810 · Tel: (203) 748-2551 · Fax: (203) 790-6375  
1389 W. Main Street, Suite 212 · Waterbury, Connecticut 06708 · Tel: (203) 755-7367 · Fax: (203) 755-1947

### Adult Neurology

Jan Mashman, M.D.  
Martin Kremenitzer, M.D.  
Diane Wirz, M.D.  
Samuel Markind, M.D.  
Neil Culligan, M.D.  
Anna Alshansky, M.D.  
David Greco, M.D.  
Robert Bonwetsch, M.D.  
Maria Sangiorgio, M.D.  
Behzad Habibi, M.D.  
Joan Ellen Gereg, APRN  
Loralee Richter, PA-C  
Melisa Pelikan, RN  
Dawn Murphy, RN

Please return completed forms sent to you plus copies of any school reports obtained in order for the doctor to review them prior to the scheduled appointment.

Thank you.

### Pediatric Neurology

Martin Kremenitzer, M.D.  
Anna Alshansky, M.D.

### Neuropsychology

Stephen Peters, Psy.D., ABN  
Michelle Bobulinski, Ph.D.  
Erin Lasher, Psy.D.

### Neurophysiology

Paulette Christie, R EEGT  
JoAnn Colucci, R EEGT

### Clinical Studies

Joan Ellen Gereg, APRN  
Margaret Mukwaya, CCRC

### Physical Therapy

Lisa Dransfield, M.A., P.T.  
Cynthia Bahr, P.T.  
Beth Capron, MPT  
Karen Nell, PTA  
Nicole Saviano, PTA  
Diane Yandow, P.T.

### Administration

Arlene Barra  
Wendy White

**Notice of Privacy Practices**  
**ASSOCIATED NEUROLOGISTS, P.C.**  
**(203-748-2551)**

**Effective Date: April 11, 2003**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

*We understand the importance of privacy, and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide, and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information*

**A. How this Medical Practice May Use or Disclose Your Health Information**

The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We may use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services, which we do not provide. We may also share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test.
2. Payment. We may use and disclose medical information about you to obtain payment for the services we provide. For example, we may give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may also use and disclose this information to request that your health plan authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your information with other health care providers, a health care clearinghouse or health plans that have a relationship with you when they request this information, to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of compliance, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.
4. Business Associates. We may share your medical information with our "business associates". We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information.
5. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information with the person answering the phone or on your answering machine. We may also mail you post cards reminding you of future appointments.
6. Sign in sheet. We may ask you to sign in when you arrive at our office. We may also call out your name when we are ready to see you.
7. Notification and communication with family. We may disclose your health information to a family member or a close friend or other person you identify where relevant to that person's involvement in your care or payment for your care. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communicating with your family and others.
8. Marketing. We may contact you to give you information about product or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and

Revised 02-01-2008

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services that may be of interest to you or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information for marketing purposes without your written authorization.

9. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings.

12. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. To avert a serious threat to health or safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

18. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

19. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record may be transferred the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

20. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

## **B. When This Medical Practice May Not Use or Disclose Your Health Information**

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information, which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time, except to the extent that we have already taken action in reliance on the authorization.

## **C. Your Health Information Rights**

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by submitting a written request specifying what information you want to limit and

what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision. Please ask for a form at the front desk.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by Connecticut law. We may deny your request under limited circumstances.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 7 (notification and communication with family) and 17 (certain government functions) of Section A of this Notice of Privacy Practices or disclosures of data which exclude direct patient identifiers for purposes of research or public health or disclosures which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities and certain other disclosures.

6. Right to Receive a Notice of Privacy Practices. You have a right to receive a paper copy of this Notice of Privacy Practices. .

#### **D. Special Rules Regarding Disclosure of Psychiatric, Substance Abuse and HIV-Related Information**

Under Connecticut or federal law, additional restrictions may apply to disclosures of health information that relates to care for psychiatric conditions, substance abuse or HIV-related testing and treatment. This information may not be disclosed without your specific written permission, except as may be specifically required or permitted by Connecticut or federal law. The following are examples of disclosures that may be made without your specific written permission:

- Psychiatric information. We may disclose psychiatric information to a mental health program if needed for your diagnosis or treatment. We may also disclose very limited psychiatric information for payment purposes.
- HIV-related information. We may disclose HIV-related information for purposes of treatment or payment.
- Substance abuse treatment. We may disclose information obtained from a substance abuse program in an emergency.

#### **E. Changes to this Notice of Privacy Practices**

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and provide you with a copy upon request.

#### **F. Complaints**

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer.

You may also submit a complaint to:

Department of Health and Human Services  
Office of Civil Rights  
Hubert H. Humphrey Bldg.  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

You will not be penalized for filing a complaint.

Revised 02-01-2008

# Acknowledgement of Receipt of Notice of Privacy Practices

Associated Neurologists, P.C.

69 Sand Pit Road, Suite 300

Danbury, CT 06810

203-748-2551

Name of Patient: \_\_\_\_\_

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

I give permission for my medical condition and/or records to be discussed with the following person (one contact, please):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

My instructions expire on: \_\_\_\_\_ OR there is no expiration: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

If not signed by the patient, please indicate your relationship to the patient: \_\_\_\_\_

\_\_\_\_\_

## *This Section for Office Use Only:*

🍏 Signed form received by: \_\_\_\_\_

🍏 Acknowledgment refused:

Efforts to obtain:

\_\_\_\_\_  
\_\_\_\_\_

Reasons for refusal:

\_\_\_\_\_  
\_\_\_\_\_