Office Use Only
Patient Name: _____
ID: _____
DB1: _____
DB2: _____

DEVELOPMENTAL BEHAVIORAL PEDIATRIC PATIENT PACKET

We ask that you fill out this packet and return it to our office before we can schedule the initial appointments. This process will ensure a more timely and efficient visit with Dr. Annelise Spees, M.D.

Your child's first two appointments will be reserved, **you must notify the office 48 hours in advance** in order to reschedule. **A "No Show" fee of $50.00 will be billed if you miss the initial evaluation appointment without prior notice.**

Should you have any questions or concerns, please call our office.

Dr. Annelise Spees, M.D., FAAP
Doctor's Medical Group of Colorado Springs
3210 North Academy Blvd., Suite 3
Colorado Springs, CO 80917
www.drannelise.com
Phone: 719-531-0409 Fax: 719-531-0410

Relationship to patient**:** _____

Consider what your concerns are at the moment. Typically, these concerns reflect problems with your child's behavioral, emotional, family, school, or social adjustment. **Take time to answer the following questions in areas that may be of concern to you.**

1. What most concerns you now about your child? (Major problematic areas.) It helps to first identify whether they are mainly problems at home, in school, in the neighborhood or community, with other children, or in all of these areas.

_____

_____

_____

_____

_____

_____

2. Please list anything that comes to mind that your child has difficulties with that might indicate a problem in these areas:
    - Health (chronic or reoccurring medical problems)

    _____

    _____

    - Intelligence or Mental Development_____

    _____

    _____

    - Motor Development and Coordination_____

    _____

    _____

    - Problems with Senses (such as eyesight, hearing, etc) _____

    _____

    _____

    - Academic Learning Abilities (such as reading, math) _____

    _____

    _____

    - Anxiety or Fears _____

    _____

    - Depression _____
    - Aggression toward Others _____
    - Hyperactivity _____
    - Poor Attention _____
    - Antisocial Behavior (such as lying, stealing, setting fires, running away)

    _____

    If taking medications for any of these concerns please note:_____

    _____

3. Are there any concerns that may be embarrassing to bring up at the visit? These often involve family problems that the parents believe may be contributing to their child's behavioral or emotional problems. The more complete the background information, the better we can understand your child, so please note your concerns below.

_____

_____

_____

_____

4. If at all possible, speak with your child's teachers before the visit. Please write down their main concern regarding your child here.

_____

_____

_____

_____

5. Sometimes daily life stress can impact your child, such as job, housing, relatives, illness, etc. Please list any problems you think are occurring in your family that might help us better understand your child better.

_____

_____

_____

_____

_____

These lists should help to focus the evaluation quickly on the most important areas of concern that you have about your child and your family. They will also probably help speed up the evaluation and keep things on track. Finally, these lists will help to maximize the usefulness of the evaluation for you and your child.

*Please see www.drannelise.com for more information on what to expect during the evaluation!

CHILD AND FAMILY INFORMATION

Child's name _____ Birth date _____ ____ Age _____

Address _____
(Street) (City) (State) (Zip)

Home Phone (_____) ____ -_____ Parent Work Phone (_____) ____ - _____

Is child adopted? Yes No If yes, age when adopted _____

If yes, does the child know he/she is adopted? Yes No

Are parents married? Yes No Separated? Yes No Divorced? Yes No

If parents are separated or divorced, is there shared custody? Yes No

Father's name _____ Age _____ Education (Years) _____

Father's place of employment _____

Type of employment _____

If separated and shared custody, father's address: _____
(Street)

_____
(City) (State) (Zip)

Mother's name _____ Age _____ Education (Years) _____

Mother's place of employment _____

Type of employment _____

If separated and shared custody, mother's address: _____
- (Street)

_____
(City) (State) (Zip)

Can we share medical information with each parent? Yes No

Child's school_____ Teacher's name _____

School Address _____
(Street) (City) (State) (Zip)

School Phone (____) ____ -_____Child's Grade_____ _____

Is child in special education? Yes No If so, what type? _____

Name of child's physician _____

Physician's telephone number (____)_____- _____

Physician's address _____
(Street) (City) (State) (Zip)

Can we share information with this provider? Yes No

PLEASE LIST ALL OTHER CHILDREN IN THE FAMILY

Name	Age	Gender	Grade in school

PLEASE LIST ALL (CHILDREN, ADULTS, ETC.) INDIVIDUALS

THAT ARE LIVING WITH THE CHILD

_____

_____

_____

PEDIATRIC HISTORY

PREGNANCY AND DELIVERY

Length of pregnancy (in weeks)? _____ How many hours of active labor? _____

Mother's age when child was born?_____ Child's birth weight: _____

Fathers' age when child was born?_____

DID ANY OF THE FOLLOWING OCCUR DURING PREGNANCY OR DELIVERY?

Bleeding excessively? _____Excessive weight gain (over 30 lbs)? _____

Did Toxemia or Preeclampsia occur? _____

Did you have to receive a Rhogam shot? _____

Did frequent nausea or vomiting occur? _____

Did serious illness or injury occur? _____

Did you take prescription medications during the pregnancy? _____

If yes the name of the medications: _____

Did you use illegal drugs or drink alcohol during or before pregnancy? _____

Did you smoke cigarettes or chew tobacco during or before pregnancy? _____

If yes, approximate number of cigarettes per day? _____

Was given medication to ease labor pains? _____

Name of medication: _____

Was the delivery induced?_____

Were forceps used during delivery? _____

Was the child delivered in a breech position? _____

Did you have Natural birth or C-Section delivery?_____

LABOR AND DELIVERY HISTORY

Was the child injured during delivery? _____

Did the child go into cardiopulmonary distress during delivery? _____

Did the child have trouble breathing following delivery? _____

Did the child need oxygen? _____ Was the child cyanotic? _____

Was the child jaundiced?_____ If so, was phototherapy used? Yes No

Did the child have any infections? _____Born with a congenital defect(s)? _____

Was in hospital more than 7 days? _____Had seizures? _____

Was given medications?_____ If yes the name of medications: _____

INFANT HEALTH AND TEMPERAMENT

DURING THE FIRST 12 MONTHS, WAS THE CHILD…

Difficult to feed? _____ Difficult to get to sleep? _____

Colicky? _____ Difficult to put on a schedule? _____

Alert? _____ Cheerful? _____

Affectionate? _____ Sociable? _____

Easy to comfort? _____ Difficult to keep busy? _____

Overactive, in constant motion? _____ Very stubborn, very challenging? _____

AT WHAT AGE DID THE CHILD…?

Sit up without help _____ Begin crawling _____

Walk alone without assistance _____

Start using single words (e.g. mama, dada) _____

Start putting 2+ words together _____

Accomplish bowel training, day and night _____

Accomplish bladder training, day and night _____

IF YOU ANSWER YES TO ANY OF THE QUESTIONS BELOW, PLEASE ALSO PUT HOW THEY ARE RELATED TO THE PATIENT. IS THERE ANY BIOLOGICAL FAMILY HISTORY OF…?

ADHD? _____

Alcoholism? _____

Arthritis? _____

Asthma? _____

Allergies? _____

Autism? _____

Bleeding problems or blood disorders? _____

Cancer of any kind? _____

Cardiovascular? _____

Diabetes? _____

Epilepsy? _____

Gastrointestinal? _____

Glaucoma? _____

Gout? _____

Growth Defects? _____

Hyperlipidemia? _____

Hypertension? _____

Heart Disease? _____

Kidney Disease?_____

Mental Illness of any kind? _____

Migraines or headaches?_____

Osteoporosis? _____

Speech Delays? _____

Stroke?_____

Tuberculosis? _____

Thyroid problems?_____

Other? _____

OTHER

Has the patient had any surgeries?_____

Is the patient currently taking any medications? _____

Does the patient have any allergies to medications or foods?_____

SAFETY

PLEASE CIRCLE ONE

Do you feel safe in your home? No Yes Exposure to AIDS: No Yes

Excessive exposure at home or work to (circle):

Fumes Dust Solvents Airborne Noise Temp

Guns in home: No Yes Seat Belt used: No Yes Have Smoke Detector: No Yes

Thank you so much for taking the time to help us understand your concerns regarding your child.

Dr. Annelise Spees, M.D., FAAP
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3210 North Academy Blvd., Suite 3
Colorado Springs, CO 80917
Phone: 719-531-0409Fax: 719-531-0410

Scan this QR code with your
smart phone to view our website

Patient Name _____

Your e-mail address_____ @ _____

Doctor's Medical Group *now has a way for you to receive messages in your email from our office in a way that keeps your private health information secure.*
Do you want us to communicate with you by email in the future? Yes____ No_____

YOUR ACCESS INFORMATION

This information must be unique for each patient chart – each family member needs a unique username/password access.

Your username: _____(first initial middle initial last name1)

(Example: John M Smith would be username jmsmith1 - MUST BE LOWERCASE)

Your password: _____ (must be at least 6 characters)

(Password must include: one letter, one number, and one character-NEITHER letter or number)

Security Question, in case you cannot remember your password (30 character max)

WebView question: _____(e.g. first pet)

WebView answer: _____ (e.g. Fido)

LOGGING IN

1. Go to this Web page address: https://webview.mckesson.com/dmgonline
2. In the **Username** field, type your username. (Keep in mind this is CASE-sensitive.)
3. In the **Password** field, type your password. (Keep in mind this is *not* case-sensitive.)
4. Click the **Login** button. The patient chart page appears.

To view your chart information once you log in

You will see your own name and DMGCS ID number. On the left sidebar menu, there is a colorful list of choices. Click on the item you want to view. The information appears in the center of the page.

Messaging

Inbox – this is where you will find any messages from our office
Deleted – items you have seen and deleted

Prescriptions

Rx – Current – this is a list from your chart of your current prescriptions

Lab

Lab Results – this shows your lab result values in a chart format
Microbiology – this shows microbiology or pathology reports
Miscellaneous – this shows lab reports as they come to our office from hospitals and labs

LOGGING OUT AND EXITING

You should always log out of your online chart when exiting, especially if you are accessing the website from a shared or public computer.

To log out

Click the Logout link that appears at the top left side of the page. The login screen will appear, verifying that you logged out successfully.

DMGCS 3210 N. Academy Blvd. #3, Colorado Springs, CO 80917 719-531-0409

Doctor's Medical Group of Colorado Springs

Pediatric Patient Information

Patient's Name_____ Date of Birth_____

Mother's Name_____ Father's name _____

Parents: _____Married ____Living together ____Divorced ____Other _____
Custody/Adoption:____ Shared Custody____ One parent has custody_____Patient is adopted

Mother's SSN_____ Father's SSN _____

Mother's DOB _____ Father's DOB _____

Home Phone _____ Alternative Phone _____

Mother's Cell Phone_____ Father's Cell Phone _____

Mother's Work Phone _____ Father's Work Phone _____

Mother's Employer_____ Father's Employer _____

Email Address _____ Email Address _____

Emergency Contact (if possible, list someone who does not live with you)

Name _____ Relationship to patient_____

Phone Number_____ Alternative Phone Number _____

Phone Contact Consent

It is the policy of Doctor's Medical Group of Colorado Springs, P.C. to call our patients to confirm/remind them of their upcoming appointment(s).

In the effort to protect your privacy (and comply with HIPAA privacy laws), we are unable to leave detailed messages for you unless we have your prior written consent. Please read the information below and carefully consider whom you want to have access to your medical information. This information may include labs, x-ray results, and billing questions/issues.

Please indicate your wishes by filling out one of the two boxes below. Please be aware that this consent will remain in effect until you rescind in writing.

I, _____ , give Doctor's Medical Group of Colorado Springs, P.C. and their staff permission to discuss my medical care with the following. I have read the policy set forth and understand that by initialing the lines below I am giving my authorization to leave messages and/or discuss the indicated matters with the people I have designated below. ***Please initial each line that applies and sign below.***

	Test Results	Billing/Financial	Any/All Matters
My Spouse (name) _____	_____	_____	_____
My home phone answering machine	_____	_____	_____
My office phone voicemail	_____	_____	_____
Other:_____	_____	_____	_____

Signature _____ Date _____

Or, if your prefer to be the only person we contact regarding this information, please fill out and sign the section below **(please do not fill out this portion if you wish to give consent above; doing so will invalidate this form).**

I, _____, wish to be contacted personally and do not authorize messages to be given to anyone other and myself or my legal guardian.

Signature _____ Date _____