PATIENT REGISTRATION FORM

Please fax (650-241-1129) or email this information to our office at least 2 days before your appointment. If it is not received, you will need to be re-scheduled. Please call our office as soon as possible to cancel or change your appointment. Our email address is: amyjoysmithnp@outlook.com.

Please complete the following:

Name _____ Date_____

Address: _____City: _____State: _____ Zip:_____

Home Phone: _____ Cell: _____ Work: _____

Email: _____

Date of Birth: _____ Age:_____ Gender:____ Occupation: _____

If minor: I live with: ☐ Parents ☐ Siblings ☐ Extended Family ☐ Other

Parents Names:	**Cell Phone:**	**Home Phone:**	**Marital Status**
_____	_____	_____	_____
_____	_____	_____	_____

Who should be contacted regarding appointments and other matters?

Self: ☐ Other person: _____

IN CASE OF EMERGENCY

Emergency Contact Person: _____ Phone Number: _____

How did you hear about Amy Smith? _____

_____

Reason for visit: _____

_____

Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices: _____

Patient/Guardian signature

I have elected not to receive a copy of the Notice of Privacy Practices: _____

Patient/Guardian signature

PATIENT MEDICAL DATA

Name _____ Date: _____

Please list all allergies and sensitivities. (drugs, foods, chemicals, environmental):

Please list all current medications (include over-the-counter and prescription medications):

Name	Dose	Frequency Taken

Supplement list (Please list all herbs, vitamins, nutritional supplements, with dosage if possible):

Please list all medical diagnoses:

Please list all surgeries (with year):

Please list all hospitalizations (with year)

Please list all therapies you use (acupuncture, massage, physical therapy etc.):

HEALTH HISTORY

Name: _____ Date: _____

Please list your health problems in order of importance to you

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

FAMILY HISTORY

	Mother	Father	Sisters	Brothers	Children
Age (if living)					
Health (Good, Fair, poor)					
Age of Death (if deceased)					

Check all that apply:	Mother	Father	Sisters	Brothers	Children
Asthma					
Allergies / Mast cell					
Autoimmune					
Cancer					
Cardiovascular/ BP					
Diabetes					
Epilepsy/ Seizures					
Food intolerance					
Heart disease					
Immune / infections					
Kidney Disease					
Mental Health Issues					
Thyroid Disease					
Other					

LIFESTYLE AND HABITS

Name: _____ Date: _____

DESCRIBE A TYPICAL MEAL:

Breakfast _____

_____

Lunch _____

_____

Dinner _____

_____

Snacks _____

_____

Drinks _____

_____

Do you:	Yes	No	
Average 6-8 hours' sleep?			What are your three favorite foods? _____
Have a supportive relationship?			_____
Have a history of abuse?			_____
Have a history of trauma?			_____
Enjoy your work?			What three foods do you dislike the most? _____
Take vacations?			_____
Spend time outside?			_____
			_____
Watch television?			How many hours weekly?
Read books?			How many hours weekly?
Computer games/browsing?			How many hours weekly?
Spiritual/religious practice?			Please Describe:
Do you smoke?			How much?
Did you smoke in the past?			How many years? How many Packs a day?
Do you eat three meals per day?			
Do you eat out often?			How many meals a week?
Do you drink coffee?			How many cups?
Do you drink tea?			How many cups?
Do you drink soft drinks?			How many a day?
Do you use sugar?			How much?
Use alcoholic beverages?			How often?

REVIEW OF SYSTEMS

Name: _____ Date: _____

Y= a problem you have now **N= never had this problem** **P= had it in the past but not now**

Mental/Emotional	**Y**	**N**	**P**
Mood Swings			
Depression			
Anxiety/Nervousness			
High Stress Level			
Memory Problems			
Considered Suicide			
Poor Concentration			
Musculoskeletal	**Y**	**N**	**P**
Joint Pain			
Joint Stiffness			
Back Pain			
Neck Pain			
Weakness			
Broken Bones			
Arthritis			
Sciatica			
Muscle Spasm			
Endocrine	**Y**	**N**	**P**
Hypothyroidism			
Hypoglycemia			
Excessive Thirst			
Fatigue			
Feel too Hot			
Feel too Cold			
Excessive Hunger			
Seasonal Depression			
Immune	**Y**	**N**	**P**
Chronic Infections			
Slow Wound Healing			
Chronic Fatigue			
Frequent Infections			

Neurologic	**Y**	**N**	**P**
Seizures			
Muscle Weakness			
Loss of Memory			
Dizziness			
Paralysis			
Numbness			
Tingling			
Skin	**Y**	**N**	**P**
Rashes			
Acne			
Boils			
Lumps			
Eczema			
Hives			
Hair Loss			
Night Sweats			
Head	**Y**	**N**	**P**
Headaches			
Migraines			
Head Injury			
Jaw/TMJ Pain			
Eyes	**Y**	**N**	**P**
Impaired Vision			
Spots in Vision			
Cataracts			
Glasses or Contacts			
Eye Pain			
Dryness			
Glaucoma			
Ears	**Y**	**N**	**P**
Impaired Hearing			
Earaches			

Ringing			
Dizziness			
Nose and Sinus	**Y**	**N**	**P**
Frequent Colds			
Stuffiness			
Sinus Pain			
Nose Bleeds			
Hay Fever			
Mouth and Throat	**Y**	**N**	**P**
Sore Throats			
Teeth Grinding			
Gum Problems			
Dental Cavities			
Jaw Clicks			
Hoarseness			
Neck	**Y**	**N**	**P**
Lumps			
Goiter			
Swollen Glands			
Pain/Stiffness			
Respiratory	**Y**	**N**	**P**
Cough			
Spitting up Blood			
Asthma			
Pneumonia			
Pain on Breathing			
Tuberculosis			
Difficulty Breathing			
Bronchitis			
Blood Vessels	**Y**	**N**	**P**
Easy Bleeding/Bruising			
Deep Leg Pain			
Varicose Veins			

REVIEW OF SYSTEMS

Name: _____ Date: _____

Y= a problem you have now **N= never had this problem** **P= had it in the past but not now**

Blood Vessels (cont.)	**Y**	**N**	**P**
Anemia			
Cold Hands/Feet			
Thrombophlebitis			
Cardiovascular	**Y**	**N**	**P**
Heart Disease			
High Blood Pressure			
Low Blood Pressure			
Blood Clots			
Phlebitis			
Rheumatic Fever			
Swelling in Ankles			
Angina			
Heart Murmurs			
Broken Bones			
Fainting			
Irregular Heartbeat			
Chest Pain			
Gastrointestinal	**Y**	**N**	**P**
Nausea			
Vomiting			
Vomiting Blood			
Trouble Swallowing			
Blood in Stool			
Pain/Cramps/Bloating			
Belching or Gas			
Gall Bladder Disease			
Liver Disease			
Heartburn			
Constipation			
Diarrhea			
Black Stools			
Ulcers			
Change in Appetite			

Hemorrhoids			
Bowel Movements-How often?			
Urinary	**Y**	**N**	**P**
Pain on Urination			
Frequency?			
Frequent Infections			
Inability to Hold Urine			
Frequency at Night?			
Kidney Stones			
Male Reproductive	**Y**	**N**	**P**
Testicular Pain			
Sexually Active			
Premature Ejaculation			
Impotence			
Prostate Disease			
Hernias			
Testicular Masses			
Sexually Transmitted Disease			
If so, what Kinds?			
Female Reproduction	**Y**	**N**	**P**
Age of First Period			
Date of Last Period			
Age of Last Period (if menopausal)			
Length of Cycles			
Are they Regular?			
Bleeding between cycles?			
Ovarian Cysts			
Clotting/Heavy Bleeding			
Discharge			
Menopause Symptoms			
Painful Periods			
Endometriosis			

Sexually Active			
Dizziness			
Birth Control			
What Type?			
Sexually Transmitted Disease			
What Kinds?			
Abnormal Pap			
Breast Lumps			
Breast Pain			
Nipple Discharge			
PMS			
What Symptoms?			
Number of Pregnancies			
Number of Live Births			
Number of Abortions			
General			
How much do you weigh?			
Are you happy with your weight? Y / N			
Childhood Illnesses (circle)			
Mumps Measles Diphtheria			
Chicken Pox German Measles			
Rheumatic Fever			
Immunizations (circle)			
Polio Tetanus Pertussis			
Measles/Mumps/Rubella			
Diphtheria Meningitis Other			
X Rays and Special Studies			
List Scans and x-rays you have had. Include			
Cat Scans, MRI Scan, X-rays, other special			
like EKGs.			

Child's Name: _____

Date: _____

PANDAS/PANS Supplemental Questionnaire

When exactly did your child's symptoms begin? _____

_____

_____

Please describe your child's symptoms at onset of PANDAS/PANS? _____

_____

_____

_____

Has family has been tested for strep? If so, when? _____

Do you or your spouse have a family history that includes frequent strep illness, rheumatic illness, scarlet fever, Lyme related infections, autoimmune illness or gluten-related issues? _____

_____

_____

On a scale of 1-10 please rate your child's *current* level of overall symptom severity _____

Has your child been diagnosed with PANDAS/PANS? _____

If so, when and by whom? _____

Do you have any other children with PANDAS/PANS or another neuropsychiatric, behavioral or developmental disorder?

_____

Please list all your child's medical diagnoses and dates of onset

Diagnosis	Date	Provider
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PANDAS/PANS Supplemental Questionnaire

How many additional/other providers have you consulted with since the onset of your child's symptoms and in which specialty?

Provider Name	Specialty	Approx. dates when started	Remarks
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Which provider(s) have helped your child the most? Name / Specialty _____

_____

Has your child ever been tested for the following? If yes, please indicate when and outcome of test. If your child was tested for Lyme related infections, please indicate which lab ran the test.

○ Strep Lab _____
○ Lyme Lab _____
○ Lyme co-infections Lab _____
○ Mycoplasma pneumonia Lab _____
○ Immune deficiency Lab _____
○ PANDAS (Cunningham Panel) Lab _____
○ Food Allergies Lab _____
○ Viral illness Lab _____
○ Autoimmune disease Lab _____
○ Functional Stool Testing or another GI workup Lab _____

Is your child in school? ○ Yes ○ No
If no, explain _____

_____

If yes, do you have a special school accommodation (IHP, IEP or 504 plan)? _____

Do you need help communicating to your child's school? _____

_____

In addition to medical care for your child and a magic wand, what else do you need for their care or your family's care at this time?

Amy Joy Smith, NP Phone: 714-782-0042 / Fax: 650-241-129

PEDIATRIC ACUTE NEUROPSYCHIATRIC SYMPTOM SCALE* Parent version

Date: **Name:** **Gender: F M**

Date of birth:

Date of onset:

Informants: **Telephone numbers**

Version: June 6, 2012

DOMAIN	One week prior to 1st Onset	Week following 1st Onset	Current (past 7 days)
Date			
Obsessive-compulsive symptoms (0-25) (5 X the worst of the OC symptoms) **			
Associated neuropsychiatric (NP) symptoms (0-25) (sum of the 5 (of 7) worst NP domains)***			
1. Anxiety symptoms (0-5)			
2. Extreme moodiness and/or depression (0-5)			
3. Irritability or aggressive behavior (0-5)			
4. Learning/cognitive symptoms, confusion (0-5)			
5. Behavioral regression (0-5)			
6.A. Sensory symptoms (0-5)			
6.B. Hallucinations (0-5)			
6.C. Motor symptoms (0-5)			
7.A. Urinary symptoms (0-5)			
7.B. Sleep disturbance, fatigue (0-5)			
7.C. Dilated pupils (0-5)			
TOTAL SYMPTOMS (0-50)			
Impairment (0-50)			
TOTAL SCORE (0-100)			

*Based on the clinical experience of Susan Swedo, M.D., Miroslav Kovacevic, M.D., Beth Latimer, M.D., and James Leckman, M.D., with the help of Diana Pohlman, Keith Moore and many other parents. **Six Obsessive-compulsive symptoms domains are presented. Rate all of them. However, on the above table only enter the score of the most severe domain (times 5; 0-25).***Seven Associated symptom domains are presented. Rate all of them. However, for each domain one or more symptom sets are listed. On the above table, only enter the score of the most severe symptom set for each domain (0-5).

Date:

Name:

SYMPTOM SEVERITY RATING SCALE (use these anchor points for each of the symptoms)

Severity ***(rate each of the symptoms listed on the following pages for the past week)***	
NONE No evidence of specific symptoms and behaviors	**0**
MINIMAL Specific symptoms and/or behaviors are present but are only evident occasionally and not a major source of difficulty.	**1**
MILD Specific symptoms and/or behaviors are present during the past week, and are episodically a source of some distress and difficulty.	**2**
MODERATE Specific symptoms and/or behaviors are present every day and are a source of distress and difficulty.	**3**
SEVERE Specific symptoms and/or behaviors are present every day and are severe resulting in a great deal of distress and difficulty.	**4**
EXTREME Specific symptoms and/or behaviors are always present and are extremely severe resulting in an extreme degree of distress and difficulty.	**5**

If multiple time points will be rated on this form, please use the following indicators:

"**B**" = Symptom severity one week ***Before*** the onset of the first episode of illness

"**O**" = Symptom severity during the week following the initial ***Onset*** of symptoms

"**C**" = ***Current*** symptom severity during the past week

Date:

Name:

Informant:

I. CORE Obsessive-compulsive Symptoms (circle and rate ALL symptoms that have been present in the past week). Use the "BOC" indicators if multiple time points are being scored (see p. 2).

Obsessive-compulsive symptoms	0 = Absent	1 = Minimal	2 = Mild	3 = Moderate	4 = Severe	5 = Extreme
Intrusive and persistent obsessional worries (anxieties) about dirt and germs and related washing compulsions (circle obsessions and/or compulsions)						
Intrusive and persistent obsessional worries (anxieties) about harm to self or others and related compulsions; a need to tell or confess (this symptom domain may be closely related to separation worries, but rate both if both are present						
Intrusive and persistent obsessional worries (anxieties) about sexual or religious thoughts or behaviors and related rituals and compulsions						
Intrusive obsessional worries about symmetry and related compulsions: ordering, counting, *or* arranging; a need to touch, tap or rub, or a need for things to feel, look, *or* sound 'just right'						

Obsessive-compulsive symptoms	0 = Absent	1 = Minimal	2 = Mild	3 = Moderate	4 = Severe	5 = Extreme
Intrusive and persistent obsessional worries (anxieties) about collecting and hoarding						
Restrictive and/or avoidant food intake symptoms; Eating or feeding disturbance (including but not limited to apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; or concern about aversive consequences of eating) resulting in a refusal to eat (atypical anorexia) or a marked decrease in food intake						
Miscellaneous. The need to know or remember; Fear of saying certain things; Fear of not saying just the right thing; Intrusive (non-violent) images; Intrusive sounds, words, music or numbers; Need to repeat activities (e.g. in/out of a doorway, up/down from chair); The need to involve another person (usually a parent) in ritual (e.g. asking a parent to repeatedly answer the same question; Mental rituals other than checking / counting; Excessive list making; Other (describe) _____ _____ _____						
Severity of all the above Obsessive-compulsive symptoms (over the past week) Five times this rating [0-25] should be entered on p. 1						

II. ASSOCIATED SYMPTOMS (circle and rate ALL symptoms that have been present in the past week). Use the "BOC" indicators if multiple time points are being scored (see p. 2).

1. Anxiety symptoms	0 = Absent	1 = Minimal	2 = Mild	3 = Moderate	4 = Severe	5 = Extreme
Separation anxiety – need to maintain proximity to person, a familiar location, or a thing						
General anxiety						
Unfounded irrational fears and/or phobias						
Panic episodes						

2. Emotional lability, depression,	0 = Absent	1 = Minimal	2 = Mild	3 = Moderate	4 = Severe	5 = Extreme
Emotional lability – mood swings - moodiness						
Depression with or without suicidal or self-injurious thoughts						

3.Increased irritability or aggressive behavior	0 = Absent	1 = Minimal	2 = Mild	3 = Moderate	4 = Severe	5 = Extreme
Increased irritability; defiant/ irrational demands; reactive aggressive behavior, temper tantrums; rage attacks						

4.Behavioral regression	0 = Absent	1 = Minimal	2 = Mild	3 = Moderate	4 = Severe	5 = Extreme
Behavioral regression (“baby talk,” behavior atypical for actual chronological age)						
Change in personality						
5. School performance Concentration/ Learning	**0 = Absent**	**1 = Minimal**	**2 = Mild**	**3 = Moderate**	**4 = Severe**	**5 = Extreme**
Difficulties in attention, concentration or learning – unable to concentrate or a clear problem with immediate or short-term memory						
Loss of academic skills – especially math or in reading or writing						
Confusion						

6.A. Sensory symptoms	0 = Absent	1 = Minimal	2 = Mild	3 = Moderate	4 = Severe	5 = Extreme
Heightened sensitivity to light, the way things “feel” (tags or labels) or “sound” or other sensory stimuli – such as smell or taste; a need to touch things in a specific way; how things “look” including spatial distortion (e.g., objects appear closer than they actually are)						

6.B. Hallucinations.	0 = Absent	1 = Minimal	2 = Mild	3 = Moderate	4 = Severe	5 = Extreme
Visual or auditory hallucinations						

6.C. Motor symptoms	0 = Absent	1 = Minimal	2 = Mild	3 = Moderate	4 = Severe	5 = Extreme
Dysgraphia (loss of ability to draw, copy figures and/or write letters)						
Motoric hyperactivity and/or adventitious movements - kicking, spitting, flailing, rolling, or stomping (do not rate tics here); unable to stay still						
Piano playing finger movements						
Simple motor tics or vocal tics (grunting, squeaking, etc.)						
Complex motor or vocal tics including spitting, obscene words or actions, repeating words or actions changes in rate or pitch of speech						

7.A. Urinary symptoms	0 = Absent	1 = Minimal	2 = Mild	3 = Moderate	4 = Severe	5 = Extreme
Urinary frequency or increased urge to urinate; daytime or night; inability to urinate						

7.B. Sleep disturbance - Fatigue	0 = Absent	1 = Minimal	2 = Mild	3 = Moderate	4 = Severe	5 = Extreme
Sleep problems (lengthy bedtime rituals, insomnia, inability to sleep; hypersomnia, nightmares)						
Extreme tiredness or fatigue						

7.C. Dilated pupils	0 = Absent	1 = Minimal	2 = Mild	3 = Moderate	4 = Severe	5 = Extreme
Dilated pupils – “terror stricken look”						

Name:

Informant:

III. Impairment Rating

Use the "BOC" indicators if multiple time points are being scored (see p. 2).

IMPAIRMENT ***(past week)***		
NONE	**0**	
MINIMAL Symptoms associated with subtle difficulties in self-esteem, family life, social acceptance, or school or job functioning (infrequent upset or concern about tics *vis a vis* the future, periodic, slight increase in family tensions because of symptoms; friends or acquaintances may occasionally notice or comment about symptoms in an upsetting way).	**10**	
MILD Symptoms associated with minor difficulties in self-esteem, family life, social acceptance, or school functioning.	**20**	
MODERATE Symptoms associated with some clear problems in self-esteem family life, social acceptance, or school or job functioning (episodes of dysphoria, periodic distress and upheaval in the family, frequent teasing by peers or episodic social avoidance, periodic interference in school performance because of PANS symptoms.	**30**	
SEVERE Symptoms associated with major difficulties in self-esteem, family life, social acceptance, or school functioning.	**40**	
EXTREME Symptoms associated with extreme difficulties in self-esteem, family life, social acceptance, or school functioning (severe depression with suicidal ideation, disruption of the family (separation/divorce, residential placement), disruption of social ties - severely restricted life because of social stigma and social avoidance, removal from school).	**50**	