



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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The Long Island Spectrum Center, a unique combination of clinical and educational professionals, is dedicated to helping kids with ADD/ADHD, behavioral problems, developmental delays; learning disabilities and autism reach their fullest potential. We achieve this goal through the innovative use of cutting-edge therapies, without the use of medication.

All day, every day, people receive information from their senses: touch, hearing, sight, taste, smell, body position, and movement and balance. The brain must organize this information so that people can successfully function in all aspects of daily life; at home, at school, at play, at work, and during social interactions. Our unique Sensory Training Program helps to integrate sensory systems that are necessary for the brain to focus, attend, expand and learn. It exercises your child's nervous system with multiple types of sensory stimuli like light, sound and motion. The center also employs the SIRRI Learning Program to improve a child's rhythm, timing, reading skills and speech. Tailored cognitive training programs use the most comprehensive computer programs, which contain different exercises to help develop attention, concentration, memory, eye-hand coordination, basic numeric concepts, problem solving-reasoning skills, self-esteem and self-control.

The unique Neuro-enhancement Therapy Program (N.E.T.) has been designed to combine The Long Island Spectrum Center Programs with nutrition/supplementation and functional neurology to treat dysfunction in the bodies of children with Autism and spectrum disorders.

Youth Evaluation Sheet

Directions: Circle impression of the following using grading system “0” not at all to “10” very severe.

Psychological/Emotional

Seems angry at times 0 1 2 3 4 5 6 7 8 9 10

Seems depressed 0 1 2 3 4 5 6 7 8 9 10

Has difficulty making friends 0 1 2 3 4 5 6 7 8 9 10

Shows poor self-esteem 0 1 2 3 4 5 6 7 8 9 10

Violent behavior 0 1 2 3 4 5 6 7 8 9 10

Physically hurts self or others 0 1 2 3 4 5 6 7 8 9 10

Score_____

Attention/Hyperactivity

Trouble staying seated for class work 0 1 2 3 4 5 6 7 8 9 10

Fidgets excessively in seat 0 1 2 3 4 5 6 7 8 9 10

Easily distracted 0 1 2 3 4 5 6 7 8 9 10

Acts before thinking 0 1 2 3 4 5 6 7 8 9 10

Interrupts, often calls out 0 1 2 3 4 5 6 7 8 9 10

Requires assistance to accurately complete assignment 0 1 2 3 4 5 6 7 8 9 10

Excessively stares or appears “spaced out” 0 1 2 3 4 5 6 7 8 9 10

Score_____

Academic

Disorganized 0 1 2 3 4 5 6 7 8 9 10

Poor math/science skills 0 1 2 3 4 5 6 7 8 9 10

Poor memory 0 1 2 3 4 5 6 7 8 9 10

Forgetful about school assignments and tasks 0 1 2 3 4 5 6 7 8 9 10

Has trouble following teacher instructions/group direction 0 1 2 3 4 5 6 7 8 9 10

Score_____

COMPREHENSIVE PEDIATRIC MEDICAL HISTORY

Confidential Medical Record – Unauthorized Use Strictly Prohibited

Confidential Patient Information

| | | | |
|----------------------------|----------------------------|----------------------------------|--------------|
| Patient Name | | Date | |
| Street Address | | City/State | Zip Code |
| Guardian Home Phone () | Guardian Work Phone () | Guardian Cell Phone/Pager () | |
| Email Address | Date of Birth | Current Age: | Years Months |
| Social Security # | Method of Payment | | |

| | |
|-----------------|----------------|
| Mothers Name: | Father's Name: |
| Legal Guardian: | Other: |

Please list all doctor's names and addresses that you have seen for this condition.

Date of last exam: _____

Diagnosis: _____

How did you hear about us?

PERSONAL HISTORY

Height Ft. _____ Inches _____ Weight Lbs. _____ Percentile Rank _____

Current School Grade: _____ Private School Public School Other

Academic Performance:

Not in School Remedial/Special Ed Below Average Average Above Average

Number of week's gestation:

Pre-term # of weeks _____ Full term (38-40 wks) Post term -# of weeks _____

Birth by: VD VD-induced C-Section Complications: No/Yes Explain _____

Birth Weight: _____ lbs _____ oz. Apgar Score: _____ / _____

Was the child breast fed? Yes # of months _____ No Formula/Type: _____

At what age was the child introduced to solid foods? _____ Any negative reactions? No/Yes _____

Estimated # of times child took antibiotics during 1st year of life: _____ Total since birth: _____

Does the child have a tendency toward constipation? No/Yes/Sometimes

How many bowel movements a day on average? 1 or less 1 2 3 more than 3

Immunizations: None/Some /All immunization up-to-date for age

Did the child have reaction(s) to any immunizations? No/Yes Explain: _____

At what age did the child first walk? _____ Average Delayed Other _____

Motor skills are considered? Good Average Delayed Other _____

Speech is considered? Good Average Delayed Other _____

How many hours/night does child sleep on average? 4-5 6-7 7-8 9-10 10+ Is sleep disturbed? No Yes

Rate the quality of sleep? 1-----2-----3-----4-----5-----6-----7-----8-----9-----10
(Poor) (Average) (Excellent)

Does the child have night terrors? Never Rarely Sometimes Often

Does the child have dark circles under their eyes? No Occasionally Often

Does the child have any unexplained rashes or itching, especially in the ears, groin or belly button? No Sometimes Often

Does the child have little bumps, pimples or scaly skin on the back of their arms? No Not sure Yes

Does the child have dry skin or eczema? No Sometimes Yes

Does the child seem to have excessive thirst? No Sometimes Yes

Does the child seem "addicted" to sugars, sweets and carbohydrates? No Sometimes Yes

Has the child's language skills seem to have regressed? No Sometimes Yes

Does the child point to objects? No Sometimes Yes

Does the child seem to avoid eye contact? No Sometimes Yes

Does the child avoid or fear strangers? No Sometimes Yes

MATERNAL HISTORY

Age of mother at pregnancy? _____ # Pregnancy: First Second Third Fourth Other _____

Did the mother have any medical problems PRIOR to pregnancy? _____

Maternal complications during pregnancy? None High blood pressure Edema Diabetes Pre-eclampsia Eclampsia

Did the mother take any medications or drugs during pregnancy? No Yes Type and Amount: _____

MEDICAL HISTORY

Has child (not a family member) ever been diagnosed with the following?

| | | |
|-------------------------------------|----------------------------------|-------------------------------------|
| ADD or ADHD | Eating Disorder | Lyme Disease |
| Allergies/Hay fever | Eczema/Psoriasis – Skin Problems | Meningitis |
| Asperger’s syndrome (AS) | Enlarged Heart | Mental Retardation |
| Asthma | Epilepsy (Seizures) | Migraine Headaches |
| Anemia | Gastric Reflux or Ulcers | Mononucleosis |
| Autism | Heart Arrhythmia | Multiple Sclerosis (MS) |
| Bladder/Urine Infection (UTI) | Heart Murmur | Obsessive Compulsive Disorder (OCD) |
| Blood Pressure Problems | Hemochromatosis (Iron Overload) | Pervasive developmental disorder |
| Colitis/Crohn’s Disease | Hepatitis/Jaundice | Sinusitis |
| Croup | Hyperthyroidism | Speech Delay |
| Developmental Delay | Hypothyroidism | Tourette’s |
| Diabetes Type I (Juvenile Diabetes) | Irritable Bowel (IBS) | Urine Infection (UTI) |
| Dysentery/Food Poisoning | Kidney Infection | Yeast Infections |
| Dyslexia | Learning Disorder | |
| Ear Infection (Otitis Media) | | |

ALLERGIES:

Is the child allergic to anything that you know of? Please list

Is the child SENSITIVE/INTOLERANT/ALLERGIC to any of the following foods?

Milk/Dairy Wheat/Gluten Peanuts Soy Eggs Corn Yeast Chocolate Citrus Fish/Shellfish
Strawberries

Other:

Does anyone in the home smoke? No Yes Type:
Cigarettes/Cigars/Pipes _____ Number/day: _____

IMMUNIZATIONS:

Has the child been immunized against?

Hepatitis B No Yes Describe _____

Heamophilis Influenza (HiB) No Yes

Describe _____

Diphtheria/Tetanus/Pertussis (DPT) No Yes

Describe _____

Chicken Pox No Yes Describe _____

Lyme Disease No Yes Describe _____

Measles-Rubeola/Mumps No Yes

Describe _____

Rubella-German.Measles No Yes

Describe _____

Polio (OPV) No Yes Describe _____

MEDICATIONS:

Please list all of the medications the child is currently taking (or recently discontinued).

OPERATIONS AND HOSPITALIZATIONS:

Has your child had any Hospitalizations or Surgeries? No Yes yr/Description

How is the child's dental health? Excellent Good Fair Poor

Has the child had an EYE exam? No Yes Date Last

Exam _____

Has the child had a HEARING exam? No Yes Date Last

Exam _____

FAMILY HISTORY:

Has any blood relative (NOT THE CHILD) ever had any of the following?

ADD/ADHD No Yes Relation_____

Asperger’s Syndrome (AS) No Yes Relation_____

Asthma No Yes Relation_____

Autism No Yes Relation_____

Bipolar Disorder No Yes Relation_____

Cancer No Yes Relation_____

Developmental Delay No Yes Relation_____

Diabetes Type I / II No Yes Relation_____

Hepatitis B or C No Yes Relation_____

Learning Disability No Yes Relation_____

Mental Illness/Suicide No Yes Relation_____

Migraine Headaches No Yes Relation_____

Obsessive Compulsive Disorder (OCD) No Yes Relation_____

PDD No Yes Relation_____

Seizure Disorder/Epilepsy No Yes Relation_____

Speech Delay No Yes Relation_____

Tourette’s Syndrome No Yes Relation_____

Other _____

DIET AND NUTRITION:

Does the child consume any of the following?

Milk - Dairy No Rarely Often -Approx glasses/day_____

Difficulty digesting Milk/Dairy (Lactose Intolerant) No Not Aware Yes

Wheat/Gluten containing grains/cereals No Rarely Often

Soda No Rarely Often -Approx glasses/day_____

Juices-Orange/Apple No Rarely Often- glasses per day_____

Soy-Containing Foods No Occasionally Often – (Circle) Soy milk Tofu Soy Protein Times/Week:_____

How many meals plus snacks per day does the child eat on average? 1 2 3 4 5 Graze

Does the child eat fruits and vegetables? Frequently Rarely Almost Never

Is the Child on any special diet? Circle

Dairy-Free Wheat/Gluten-Free Yeast-Free Feingold Low Carbohydrate High Protein No Special Diet

Other:_____

Please list the foods that the child ate yesterday for:

Breakfast

Lunch

Dinner

Snacks

Please list the foods in the child's "usual" daily diet for: (Please be specific):

Breakfast

Lunch

Dinner

Snacks

Name the five foods consumed MOST frequently by the child. (Please be specific)

1. _____
2. _____
3. _____
4. _____
5. _____

List all vitamins, minerals, herbs, amino acids, and nutritional supplements (with dose) the child is taking on a regular basis:

Have you ever tried any alternative therapies? If so, which?



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 must disclose your health information to you, as described in the Patient Rights section of this Notice. 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

Long Island Spectrum Center
100 Manetto Hill Road, Suite 106
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516-470-9525

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 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 _____