Child and Adolescent Neurology

Patient Information Questionnaire

Today's Date: ________/_______/_______

Patient's Name: ________________________, ____________________, ______ Age:_______________
(Last) (First) (M.I.)

Preferred Name (nickname): _______________________________
Name of Person Completing this form: ___________________________________
Relationship to Patient: ____

*What is the main reason for the appointment (Chief Complaint)? ____________________________
Who referred you to Neurology (Referring Physician): _______________________________________

*Learning Barriers: Please check any that apply to the primary caregiver of the patient.

□ None
□ Hearing
□ Sight
□ Language
□ Physical
□ Cognitive
□ Motivation
□ Cultural
□ Religious
□ Mental Health

PAST MEDICAL HISTORY

*Please list all current and previous medical diagnoses (asthma, epilepsy, etc):

1. ____
2. ____
3. ____
4. ____
5. ____

Other specialists who see the patient: ____

PROCEDURE HISTORY

Operations:	**Approximate Date**	**Age at time of procedure:**
1. ________________________________	__________________	_________________
2. ________________________________	__________________	_________________
3. ________________________________	__________________	_________________

Hospitalizations:

Hospital Name	**Approximate Date**	**Age at time of hospital stay:**
1. ________________________________	__________________	_________________
2. ________________________________	__________________	_________________
3. ________________________________	__________________	_________________

BIRTH AND DEVELOPMENTAL HISTORY

Birth History

Maternal age at delivery: __________years
City/State where patient was born: ______________________________
Was the patient born full term? ☐ Yes ☐ No
Duration of Pregnancy (months/weeks) ______________________ Due Date ____________
Pregnancy Complications: ______________________________
Medications used during pregnancy: ______________________________
Did the mother drink alcohol , smoke or use drugs during pregnancy? ☐ Alcohol ☐ Smoke ☐Drug Use
If yes, please explain ______________________________
Did mother have any history of pregnancy losses? (If yes, how many?): ____________________
Check type of delivery: ☐ Vaginal ☐ C-Section ☐ Forceps ☐ Vacuum
Delivery Complications: ______________________________
Birth weight: ____________________
Apgar Scores (if known): 1 min.: _____________ 5 mins.: __________
How long was the hospital stay? ______________________________
Were there any concerns noted at birth or special care required in the hospital (describe): ________________
____

Developmental History

Please note the age (in months/years) when the patient achieved these abilities (to the best of your knowledge)

Gross Motor		Fine Motor		Expressive Language, Self-Help		Receptive Language	
Rolled over		Reached		Babbled		Turned head to voice	
Sat alone		Transferred		Laughed		Understood "No"	
Crawled		Ate w/fingers		Said Mama, Dada		Followed 1 step commands	
Pulled to stand		Pincer grasp		Single words		Followed 2 step commands	
Cruised		Used fork/spoon		2 words together			
Walked alone		Scribbled		Knew name, age, gender			
Ran well		Caught a ball		Learned colors			
Pedaled Tricycle		Undressed		Potty trained			
Pedaled Bicycle		Dressed		Told a story			
		Tied shoes					

Is the patient Left or Right handed? ______________
Is the patient receiving any services: ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy
For girls, age of first menstrual period: ______________ Regular Cycles? _____________

FAMILY HISTORY

*Please identify (with a check mark) family members with any of the following conditions:

	Mother	Father	Brother	Sister	Other (specify)
ADD\ADHD					
Anxiety Disorder					
Bipolar					
Cancer					
Cerebral Palsy					
Depression					
Epilepsy					
Headache/Migraine					
Intellectual Disability					
Multiple Sclerosis					
Muscular Dystrophy					
Narcolepsy					
Neuropathy					
Obsessive Compulsive Disorder					
Schizophrenia					
Seizures					
Sleep Apnea					
Stroke					
Thyroid disease					
Tic or Movement Disorder					
Vision Impairment					

Other diseases of the brain, spinal cord, nerves or muscles (please list): ____________________________________

SOCIAL HISTORY

***Substances:**

Does the patient use alcohol, tobacco, or illegal drugs?

Alcohol Use: □ Yes □ No Type ______________ Frequency ________________

Drug Use: □ Yes □ No Type ___________ Frequency ________________

Tobacco Use: □ Yes □ No Type: □ Cigarettes □ Cigars □ e-Cigarettes/Vapor □ Oral □ Pipe □ Other

Daily Usage: ________________

Second Hand Smoke Exposure: □ None □ Exposed inside the home □ Caregiver smokes outside the home

Exposure to smoke during pregnancy □ Yes □ No ________________________

Home:

Please list individuals in the home who live with the patient:____

Father's Name:____Height__________Age_____________

Highest Grade Completed:____ Occupation:____

Mother's Name:____Height__________Age_____

Highest Grade Completed:____ Occupation:____

Where does the patient live? □ Single family home □ Apartment □ Trailer □ Other ___________________

Education:

Name of patient's school:____ Current grade: _______________

How are school performance and grades?____

Is the patient receiving special assistance or in special classes? Please describe: ____________________________

Does the patient have (Check all that apply): □ 504 Plan □ Individualized Education Plan (IEP)

Has he/she repeated grades? If so, what grade and explain:____

Has the patient had excessive absences from school? □ Yes □ No

Are there any problems at school? □ Yes □ No Any suspensions? □ Yes □ No

Comments: ____

Hobbies/Sports/Activities: ____

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* REVIEW OF SYSTEMS

Please answer the following questions about symptoms your child is **CURRENTLY** experiencing. Check all that apply.

General	☐ Negative ☐ Fatigue ☐ Sweats ☐ Change in appetite ☐ Weight Loss ☐ See comment ☐ Fever ☐ Chills ☐ Bleeding problems ☐ Nutritional concerns ☐ Weight gain
Comment	
Head	☐ Negative ☐ Headaches ☐ HX of head injury/concussion ☐ See comment
Comment	
Eyes	☐ Negative ☐ Itching ☐ Glaucoma ☐ Corrective lenses/contacts ☐ Impaired vision ☐ Dryness ☐ Infection ☐ See comment ☐ Pain ☐ Redness ☐ Double vision
Comment	
Ears	☐ Negative ☐ Deafness ☐ Pain ☐ Dizziness ☐ Impaired hearing ☐ Discharge ☐ Ringing in the ears ☐ See comment
Comment	
Nose and Sinuses	☐ Negative ☐ Dryness ☐ Obstruction ☐ See comment ☐ Diminshed sense of smell ☐ Pain ☐ Sinusitis ☐ Bleeding ☐ Discharge ☐ Seasonal allergies
Comment	
Mouth and Throat	☐ Negative ☐ Infection ☐ Blisters ☐ Difficulty swallowing ☐ Dental problems ☐ Sore throat ☐ Sore tongue ☐ Lip lesions ☐ Hoarseness ☐ See comment ☐ Pain ☐ Ulcers ☐ Canker sores ☐ Tonsilitis
Comment	
Neck	☐ Negative ☐ Limited motion ☐ Lumps ☐ See comment ☐ Stiffness ☐ Pain ☐ Swollen glands
Comment	
Breasts	☐ Negative ☐ Discharge ☐ Bleeding ☐ Retraction ☐ Tenderness ☐ Size ☐ See comment
Comment	
Skin	☐ Negative ☐ Itching ☐ Moles/changes ☐ Hair/changes ☐ Tumors ☐ Hives ☐ See comment ☐ Rash ☐ Color change ☐ Infection ☐ Nails/changes ☐ Sores ☐ Lesion
Comment	
Respiratory	☐ Negative ☐ Asthma ☐ Exposure to tuberculosis ☐ Cough ☐ Pneumonia ☐ Cyanosis (Bluish tint to skin, lips, nails) ☐ Chest pain ☐ Sputum (color/frequency) ☐ Shortness of breath ☐ Wheezing ☐ Recurrent infection ☐ See comment
Comment	
Cardiovascular	☐ Negative ☐ Difficulty Breathing ☐ Varicose veins ☐ Chest pain ☐ Shortness of breath during exercise ☐ See comment ☐ Murmur ☐ Fainting ☐ Palpitations ☐ Phlebitis
Comment	

Hematologic / Lymphatic	☐ Negative ☐ Anemia ☐ Bleeding ☐ Malignancy ☐ Swollen lymph nodes ☐ Transfusion ☐ See comment
Comment	

Gastrointestinal	☐ Negative ☐ Nausea ☐ Vomiting ☐ Vomiting blood ☐ Diarrhea ☐ Heartburn ☐ Food intolerance ☐ Change in bowel habits ☐ Hernia ☐ Constipation ☐ Laxative or enema use ☐ Ulcers ☐ Abdominal pain ☐ Belching ☐ Black stools ☐ Stooling "accidents" ☐ Bloating ☐ Hemorrhoids ☐ See comment
Comment	
Genitourinary	☐ Negative ☐ Burning ☐ Hesitancy ☐ Infection ☐ Urgency ☐ Blood in urine ☐ Incontinence ☐ Kidney stones ☐ Bedwetting ☐ Leakage ☐ Frequency ☐ Toilet trained ☐ See comment
Comment	
Reproductive	☐ Negative ☐ Discharge ☐ Itching ☐ Infection ☐ Started menstrual cycle ☐ Painful menstrual cramps ☐ Contraceptive use ☐ Complication of pregnancy ☐ Sexually transmitted disease ☐ Childbirth ☐ Abortion ☐ Painful intercourse ☐ See comment
Comment	
Musculoskeletal	☐ Negative ☐ Muscle cramps ☐ Pain ☐ Weakness ☐ Atrophy ☐ Swelling ☐ Joint pain ☐ Fractures ☐ Back Injury ☐ Curvature of spine ☐ See comment
Comment	
Endocrine / Metabolic	☐ Negative ☐ Heat or cold intolerance ☐ Diabetes ☐ Hair/changes ☐ Excessive sweating ☐ Thirst ☐ Urinary frequency ☐ See comment
Comment	
Neurologic	☐ Negative ☐ Headaches ☐ Fainting ☐ Seizures ☐ Dizziness ☐ Blindness ☐ Double vision ☐ Vision loss or change ☐ Paralysis ☐ Pain ☐ Numbness ☐ Tic ☐ Tingling ☐ Burning ☐ Poor coordination or balance ☐ Learning problems ☐ Attention problems ☐ Hyperactivity ☐ Developmental delay ☐ Unusual development/behavior ☐ Short attention span ☐ See comment
Comment	
Psychiatric / Emotional	☐ Negative ☐ Sleep disturbances ☐ Unhappy, down or hopeless ☐ Suicidal expression or self-injurious behavior ☐ Severe mood swings ☐ Excessive worries or fears ☐ Fidgety, unable to sit still or trouble concentrating ☐ Does not play with others or has few friends ☐ Fights with other children ☐ Defiant or argumentative with adults ☐ Suspected drug or alcohol use ☐ Strange or nonsensical thinking or behavior ☐ Recent changes in family or school ☐ See comment
Comment	

_______________________________ Clinician Signature

_______________________________ Date