Name: **DOB:** **DOS:** **MRN:**

INTAKE QUESTIONNAIRE: PEDIATRIC NEUROLOGY

Appointment Date:_____ Patient Name:_____

Patient's age (in years and months) _____Patient's School and Grade:_____

Full name, address and phone number of Pediatrician:_____

_____

Please briefly state the reason for this visit and your expectations from it. What problems have you noticed? What has your pediatrician thought or done? What have teachers or school personnel said?

_____

_____

_____

_____

_____

_____

_____

_____

SYSTEM REVIEW:

Please indicate if your child has symptoms or known illnesses affecting any of the following organ systems:
Cardiac/circulatory: _____
Renal/urinary: _____
Hematologic: _____
Visual: _____
Pulmonary: _____
Dermatologic: _____
Muskuloskeletal: _____
Ear/Nose/Throat: _____
Gastrointestinal: _____
Endocrinologic: _____
Immunologic: _____

NEUROLOGIC HISTORY

Please indicate if your child has any of the following and give dates of occurrence:
Seizures or convulsions _____
Nervous tics_____
Head injury with loss of consciousness: _____
Meningitis or other brain/spine infections: _____

HOSPITALIZATIONS: _____
SURGERIES: _____
CURRENT MEDICATIONS (Give doses)_____
ALLERGIES: _____
DIET (Choose one): Regular____ Medically restricted (e.g., lactose intolerance)_____

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BIRTH HISTORY:

Was the baby adopted by you? ____ If so, at what age?_____
Child's Birthplace_____ Birth Weight_____
Mother's Age at Child's Birth_____ Duration of Pregnancy_____weeks
Medication(s) taken during pregnancy_____
History of Miscarriage or Premature Births_____
Labor Type (please circle one) *spontaneous* *induced*
Length of Labor_____ What age did the baby come home?_____
Delivery Mode (please circle one) *vaginal* *cesarean section*
Baby's Response (please circle one) *spontaneously breathing* *needed resuscitation*
Newborn Care (please circle one) *regular nursery* *special care nursery*
Were there any complications with the birth? (i.e. seizures, birth injury, etc.)_____

DEVELOPMENTAL HISTORY

Please supply approximate age at which each of these developmental milestones occurred. If you cannot remember, indicate "normal" or "late."

Gross Motor Development		Language Development	
Lifts Head	*Age*_____	Babbles	*Age*_____
Rolls Over	*Age*_____	Says MaMa/DaDa specifically	*Age*_____
Sits without support	*Age*_____	Speaks single words	*Age*_____
Pulls to stand	*Age*_____	Combines two words	*Age*_____
Crawls	*Age*_____	Recognizes colors	*Age*_____
Walks well	*Age*_____	Gives alphabet	*Age*_____
		Counts to ten	*Age*_____

Fine Motor Development		Social Development	
Reaches for objects	*Age*_____	Responsive Smile	*Age*_____
Passes objects hand to hand	*Age*_____	Plays Peek-a-Boo	*Age*_____
Pincer (finger-thumb) Grasp	*Age*_____	Initially shy with Strangers	*Age*_____
Scribbles	*Age*_____	Imitates Housework	*Age*_____
Forms letters	*Age*_____	Dresses Self	*Age*_____

FAMILY HISTORY

If any family members have the following diagnoses, please indicate and give relationship to child:

Hyperactivity or attention deficit _____ Seizures/Epilepsy _____
School or learning problems _____ Nervous tics _____
Speech or language problems _____ Depression/Psychiatric illness _____
Mental Retardation _____ Sleep Disorder _____
Migraine Headaches _____

SOCIAL HISTORY

Mother's Name:_____ Age: __ Occupation: _____
Father's Name: _____ Age: __ Occupation: _____

The child resides with: (please circle) Mother Father Both

Ages of brothers if any: _____
Ages of sisters if any: _____
Child's school and grade:_____
Child's favorite extracurricular activities:_____

Name: **DOB:** **DOS:** **MRN:**

BEHAVIOR QUESTIONNAIRE

Please endorse all descriptors that apply to your child:

___1. Does not use nonverbal behaviors well (eye-to-eye gaze, facial expression, body postures, and gestures) to regulate social interaction.

___2. Has not developed peer relationships as well as other children his/her age or developmental level.

___3. Does not spontaneously share enjoyment, interests or achievements with other people (e.g. by showing, bringing, or pointing out objects of interest.)

___4. Does not socialize or interact on the emotional level with others.

Comments, examples or counter examples: _____

_____

___5. Has a delay in, or total lack of the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)

___6. If adequate speech is present, has marked impairment in the ability to initiate or sustain a conversation with others.

___ 7. Has stereotyped and repetitive use of language or idiosyncratic language.

___8. Has lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

Comments, examples or counter examples: _____

_____

___9. Has an encompassing pre-occupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.

___10. Has an apparently inflexible adherence to specific, nonfunctional routines or rituals.

___11. Has stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole body movements).

___12. Has persistent pre-occupation with parts of objects.

Comments, examples or counterexamples: _____

_____

___13. Has a delay or abnormal functioning in social interaction with onset prior to 3 years of age.

___14. Has a delay in use of language for social communication with onset prior to 3 years of age.

___15. Has a delay or abnormal functioning in symbolic or imaginative play with onset prior to 3 years of age.

16. At what age do you estimate your child's motor development? _____

17. At what age do you estimate your child's language development? ____

18. At what age do you estimate your child's problem solving skills? ____

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SCHOOL QUESTIONNAIRE: (Parent/s fill in the information below).

___(a) often fails to give attention to details or makes careless mistakes in schoolwork, work, or other activities
___(b) often has difficulty sustaining attention in tasks or play activities
___(c) often does not seem to listen when spoken to directly
___(d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand directions)
___(e) often has difficulty organizing tasks and activities
___(f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
___(g) often loses things necessary for tasks and activities(i.e.: toys, school assignments, pencils, books, or tools)
___(h) is often easily distracted by extraneous stimuli
___(i) is often forgetful in daily activities

___ (j) often fidgets with hands or feet, or squirms in seat
___ (k) often leaves seat in classroom or in other situations where remaining seated is expected
___ (l) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
___(m) often has difficulty playing or engaging in leisure activities quietly
___(n) is often "on the go" or often acts as if "driven by a motor"
___(o) often talks excessively
___(p) often blurts out answers before questions have been completed
___(q) often has difficulty awaiting turn
___(r) often interrupts or intrudes on others (i.e.: butts into conversations or games)

•Beside each item below, indicate the degree of the problem by a check mark.

	not at all	just a little	pretty much	very much
•excitable, impulsive	_____	_____	_____	_____
•cries easily or often	_____	_____	_____	_____
•restless in the "squirmy sense"	_____	_____	_____	_____
•restless, always up and on the go	_____	_____	_____	_____
•destructive	_____	_____	_____	_____
•fails to finish things	_____	_____	_____	_____
•distractibility or attention span problem	_____	_____	_____	_____
•mood changes drastically or quickly	_____	_____	_____	_____
•easily frustrated in efforts	_____	_____	_____	_____
•disturbs other children	_____	_____	_____	_____

Name: **DOB:** **DOS:** **MRN:**

HEADACHE QUESTIONNAIRE

1. How long ago did the headaches begin? _____
2. Are there any precipitants, such as food or activity? (please specify)
   _____
3. Is there a family history of migraines? (if so, who is affected) _____
   _____
4. Is there a history of car sickness? _____
5. How long do the headaches usually last? (please specify number of hours or days)
   _____
6. In the last 2 months, what is the headache frequency (in headaches per month):
   _____
7. Prior to that time, what was the headache frequency (in headaches per month):
   _____
8. Are the headaches similar to each other? _____
   _____

9. Are the headaches one sided?	Y	N
10. Do the headaches have a throbbing quality?	Y	N
11. Do the headaches interfere with daily activities?	Y	N
If so, how? _____		
12. Do headaches become worse with physical activities?	Y	N
13. Are the headaches associated with nausea and/or vomiting?	Y	N
14. During headaches, is there sensitivity to light?	Y	N
15. During headaches, is there sensitivity to sound?	Y	N
16. Is there a warning that immediately precedes headaches (aura)?	Y	N
a. If so, are the symptoms of the aura fully reversible?	Y	N
b. If so, does the aura develop gradually over more than 4 minutes?	Y	N
c. Does the aura last less than 1 hour?	Y	N
d. When an aura occurs, does a headache follow within I hour?	Y	N
e. Does the aura cause difficulty with speech?	Y	N
f. Does the aura include dizziness?	Y	N
g. Does the aura include ringing in the ears?	Y	N
h. Does the aura include decreased hearing?	Y	N
i. Does the aura include double vision?	Y	N
j. Does the aura include a staggering gait?	Y	N
k. Does the aura include numbness, tingling, or decreased feeling?	Y	N
If so, where: _____		
_____		
l. Does the aura include complete or partial paralysis?	Y	N
If so, where: _____		
_____		
m. Does the aura include decreased level of awareness?	Y	N
17. Can 2 types of headaches be distinguished, migraine and tension?	Y	N

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FOR PATIENTS WITH SUSPECTED SLEEP DISORDERS:

OVERNIGHT SLEEP

	On weekdays	On weekends / vacations
• Bedtime ("lights out"):		
• Length of time it takes to fall asleep:		
• Average number of awakenings per night		
• The time of waking up in the morning:		

In the morning, does you child frequently

- have a hard time waking up? **Yes** **No**
- feel tired / unrefreshed? **Yes** **No**
- look irritable? **Yes** **No**
- have a headache? **Yes** **No**

Does you child take naps regularly? Yes No

If answered "YES"

How many naps a day? _____

What time of the day is the nap taken? _____

Is your child refreshed after naps? **Yes** **No**

Do you think that your child

- is sleepy during the day? **Yes** **No**
- has ever stopped growing at a normal rate at any time since birth? **Yes** **No**
- is breathing through the mouth during the day? **Yes** **No**

While asleep, does your child

- snore? **Yes** **No**
- have heavy or loud breathing? **Yes** **No**
- gasp for breath? **Yes** **No**
- ever stop breathing? **Yes** **No**
- breath through the mouth? **Yes** **No**
- cough frequently **Yes** **No**
- get up frequently to urinate? **Yes** **No**
- wet the bed? **Yes** **No**
- move around frequently? **Yes** **No**
- have frequent kicks or jerks with the legs? **Yes** **No**

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Does your child ever

- have discomfort or pain in his/her legs in the evening? **Yes** **No**
- have discomfort or pain in his/her legs while resting? **Yes** **No**
- have "growing pains"? **Yes** **No**
- ask you to massage his/her legs? **Yes** **No**

Does your child

- have nightmares (bad dreams) that he / she remembers in t **Yes** **No**
  morning? (if answered "yes": at what age? _____)

Has your child

- ever had night terrors, when he/she will sit up, scream, **Yes** **No**
  and does not remember it in the morning?
  (if answered "yes": at what age? _____)

Has your child

- ever walked in his/her sleep? (if answered "yes": at what age? _____) **Yes** **No**
- ever been eating or drinking in his / her sleep? **Yes** **No**
- ever lost strength in the legs and fallen while excited, laughing or crying? **Yes** **No**
- ever felt unable to move during waking up from sleep? **Yes** **No**
- ever seen scary dreams or images as going to sleep or waking up? **Yes** **No**

Is your child

- a"morning person"? **Yes** **No**
- an"evening person"? **Yes** **No**

Does your child

- have good appetite in the morning? **Yes** **No**

Between which hours of the day is your child

- the most tired / sleepy? _____
- the most alert and/or physically active? _____