General Pediatric Neurology Intake Questionnaire

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?

_____

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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: _____
Musculoskeletal: _____
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 _____
Tics or tremors _____
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) _____

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 (fill out if or as it applies to this visit)

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 _____
School or learning problems _____
Speech or language problems _____
Mental Retardation _____
Migraine Headaches _____
Seizures/Epilepsy _____
Tics or tremors _____
Depression/Psychiatric illness _____
Sleep Disorder _____

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: _____