PATIENT INFORMATION-PEDIATRIC NEUROLOGY CONSULTATION

*This detailed **(confidential)** information will help your doctor identify areas of concern for your child. Some sections may not apply to your child, but please complete as many sections as possible. This information will be considered a confidential part of the medical record.*

Name: ***Date of Birth:*** ***Account Number:***

Age: Handedness: ___right ___left ___not established yet

Preferred Name: _____ he/him she/her they/them

School Name: _____ School Grade: _____

Pediatrician or family doctor: _____

Birth and pregnancy history:

Birth weight: _____ Born at _____ weeks of pregnancy ___vaginal ___c-section

Medication during pregnancy: _____ ___none

Hospital name: _____

Nursery stay: ___3 days or less ___more than 3 days - How long? _____

Other comments: _____

Developmental history:

Do you have concerns about your child's development? ___no ___yes

If yes, please explain: _____

Has your child ever had loss of speech or developmental skills? ___no ___yes

Does your child receive: Physical therapy? ___no ___yes

Occupational therapy? ___no ___yes

Speech therapy? ___no ___yes

Past medical history:

Has your child been diagnosed with any medical conditions or developmental problems?___no___yes

If yes, please explain: _____

_____

_____

_____

Has your child ever been hospitalized? ___no ___yes

If yes, please provide month/year and reason: _____

_____

_____

_____

Has your child had any surgeries? ___no ___yes

If yes, please provide details: _____

_____

_____

Name: ***Date of Birth:*** ***Account Number:***

Current medications:

Please list any medications your child takes, including vitamins or supplements.

Name: _____ Dose: _____

_____ _____

_____ _____

Does your child have a medication allergy? ___no ___yes

Please list any medication allergies: _____

Please list any alternative, chiropractic, or supplemental therapies: _____

Medication history:

Please list any medications your child has previously tried for the condition that brings you to the neurologist today._____

_____

_____

Academic performance:

Academic concerns? ___no ___yes

If yes, please explain:

_____

Recent worsening of school performance: ___no ___yes

Special education services, IEP, EBD, or chapter/title services? ___no ___yes

Sports/activities: _____

Psychosocial:

Does your child live with: ___one parent ___both parents ___shared custody

Does your child attend daycare? ___no ___yes

Does your child smoke/vape? ___no ___yes ___unknown

Is anyone abusing your child physically, emotionally or sexually? ___no ___yes

Has your child been abused in the past? ___no ___yes

Does your child have problems making and maintaining eye contact? ___no ___yes

Does your child interact well with other children? ___no ___yes

System review:

Please mark any of the following that apply to your child:

___Unexpected weight gain or loss	___Diarrhea	___Learning disabilities
___Vision changes	___Urinary incontinence	___Seems depressed
___Hearing difficulty	___Muscle pain	___Seems anxious
___Snoring	___Joint pain	___Excessive sleepiness
___Chest pain	___Rash	___Abnormal movements
___Heart palpitations	___Birthmarks	___Difficulty walking
___Breathing difficulty	___Fainting/passing out	___Difficulty sleeping
___Stomachaches	___Headaches	___Excessive daytime fatigue
___Constipation	___Seizures	___Other: _____

Name: ***Date of Birth:*** ***Account Number:***

When was vision last checked? _____ ___never
When was hearing last checked? _____ ___never

Family history: ❑ **Family history unknown**

Some genetic and acquired conditions are associated with ethnic origin and occupational factors. Please specify for example whether they were English, Danish, French, Swiss, Eastern European, Mexican, etc.

Parents	**Age**	**Health condition**	**Occupation**	**Ethnicity**	**Lives at Home**
Biologic father					___no __yes
Biologic mother					___no __yes
Brother (s)					___no __yes
					___no __yes
					___no __yes
Sister(s)					___no __yes
					___no __yes
					___no __yes

Has any relative (biologic relative to the patient) had any of the following difficulties?

Seizures	___no	___yes	Who? _____
Headaches	___no	___yes	Who? _____
Autism	___no	___yes	Who? _____
ADD/ADHD	___no	___yes	Who? _____
Learning disability	___no	___yes	Who? _____
Neuropathy	___no	___yes	Who? _____
Tics	___no	___yes	Who? _____
Depression	___no	___yes	Who? _____
Anxiety	___no	___yes	Who?_____
Bipolar, manic/depressive	___no	___yes	Who? _____
Schizophrenia	___no	___yes	Who? _____
Brain tumor	___no	___yes	Who? _____
Multiple sclerosis	___no	___yes	Who? _____
Aneurysm	___no	___yes	Who? _____
Stroke under age 50	___no	___yes	Who? _____
Heart attack under age 50	___no	___yes	Who? _____
Multiple miscarriages	___no	___yes	Who? _____
Blood clotting disorder	___no	___yes	Who? _____
Genetic condition	___no	___yes	Who? _____
Autoimmune conditions	___no	___yes	Who? _____
Other	_____		

Person who completed form: _____

Signature: _____ **Date:** _____