Pediatric Neurology of Lehigh Valley
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INITIAL PATIENT INFORMATION QUESTIONNAIRE

Parents/ Guardians: Please help us provide the best possible care for your child by filling out this form.

Patient Name:_____DOB:_____
Last First M

Name of person completing form:_____ Relationship to patient:_____
How did you hear about our office?_____

Primary Physician: _____ Phone: _____
Address: _____

Reason for today's consultation?

Main questions or concerns regarding your child?
1. _____
2. _____
3. _____

What are your expectations for this evaluation?_____
_____

Has your child seen another neurologist, developmental pediatrician or psychiatrist in the past for your current concern?
□No □Yes If so, please provide Name & Address.
_____
_____

Please indicate if your child is: □ Left Handed □Right Handed □Ambidextrous □No Preference

Current Medications (Feel free to attach a medication sheet if there is not enough space provided.)

Medication Name	Dose	How Often

Vitamins/ Supplements:
_____
_____

Drug Allergies/ Adverse Reactions (Please list drug and reaction):

_____

_____

Food/Seasonal Allergies

_____ _____ _____ _____

Does you child have an allergy to Latex? □No □Yes

Immunizations: □ Up to date □ Up to date but given on delayed schedule □ Not up to date/ deferred
If not up to date, please explain: _____

Past Medical History

Please list known prior medical diagnoses below.

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Other:

Has your child ever had (Please check all that apply)

□ Seizures □ Meningitis/Encephalitis □ Head Injury/Concussion Explain _____

_____Has your child ever been hospitalized? □No □Yes. Explain. (Please include dates and reason)

_____

_____

Has your child ever had surgery? □No □Yes. Explain. (Please include dates and type)

_____

_____

Does your child experience hearing difficulties? □No □Yes. Explain. _____

Has your child ever had a formal hearing evaluation since newborn period? □No □ Yes. Explain. (Please include dates, where performed, and results) _____

Does your child experience vision difficulties? □No □Yes. Explain. _____

Has your child been seen by an eye specialist? □No □Yes. Results: _____

Does your child wear glasses or contact lenses? □No □Yes

Comments: _____

_____

Has you child ever had neuroimaging (Brain MRI, Head CT, etc.)? □No □Yes. (Please include dates, where performed, and results)

Has you child ever had an EEG? □No □ Yes. (Please include dates, where performed, and results)

Birth History:

□ PLEASE CHECK if patient is ADOPTED. If so, can this be discussed in front of patient? □ Yes □ No

Did mother receive regular prenatal care? □No □Yes

Did mother have exposure to any of the following? □Drug Use □ Alcohol Use □ Cigarettes

If so, please describe the substance and extent of exposure

Non-prescription medication taken during pregnancy: _____

Prescription Medication taken during pregnancy:_____

Birth Weight: _____Mother's Age at time of delivery: _____Father's Age at time of delivery: _____

How many weeks was the pregnancy: _____ What number pregnancy was your child: _____

What number live birth was your child: _____ Mode of Delivery: □ Vaginal □ Cesarean

Use of assistive devices (forceps or vacuum): □No □Yes. Explain._____

Has mother had any (check all that apply): □ Miscarriages □ Stillbirths □ Terminations

If so, please provide any relevant medical reasons (genetic defect, ectopic pregnancy, etc.) _____

_____

Did mother have any health problems during this pregnancy? Check all that apply.

□Anemia □ Bleeding □Diabetes □Fever □Frequent Illness/Infection □Excessive Vomiting

□High Blood Pressure □Preeclampsia/Eclampsia/Toxemia □Surgery □Other _____

Additional comments:

Were there any complications during labor or at the delivery? □ No □ Yes.

Explain._____

_____

Did your child show any of the following signs of distress during or immediately after the birth?

□Poor Color □Not Breathing □Not Crying □Cord wrapped around neck □Poor APGAR Score

Did your child require any form of resuscitation at delivery? Check all that apply. □ Oxygen

□Medication □ Chest Compressions □ Other. Explain. _____

_____

Did your child have any of the following medical difficulties in the newborn period? □Apnea or Bradycardia □Jaundice (□ Phototherapy) □ Seizures □Infections □Anemia (□Transfusion) □Low Blood Sugar □ Other. Explain._____

_____

Was there a need for your child to be admitted to the NICU (neonatal intensive care unit) following the birth? □No □Yes. If so, please describe (Duration of stay, need for breathing support, feeding tube, etc.)

_____

_____

Additional comments:

Developmental History:

Has your child ever experienced any delayed verbal or motor milestones? □ No □ Yes

Has your child ever experienced any regression, or lost any motor or verbal skills they once possessed? □No □Yes

❖If you have no concerns regarding your child's development, then skip to Educational History❖

To the best of your knowledge, please indicate the age at which your child developed the following skills. If you cannot recall the exact age, indicate whether NL for normal, ADV for advanced, or D for delayed

Head Control		Pointed Purposefully	
Rolled Over		Said First Words	
Sat Alone		Used 2-Word Phrases	
Crawled		Used 3-Word Phrases	
Babbled (gaga, dada)		Identified Body Parts	
Pulled to Stand		Read	
Cruised Furniture		Wrote Name	
Walked Alone		Rode a Bike	

Is your child toilet trained? □No □Yes. If so, please indicate when._____

Has your child had poor hand coordination? (i.e., trouble with buttoning, snaps, opening bottles, tying shoes) □No □Yes. Describe._____

_____

Does your child have difficulty with overall body coordination? (i.e., learning how to kick or throw a ball, frequent falls) □No □Yes. Describe. _____

_____

Is your child overly sensitive to any of the following stimuli? Check all that apply. □Light □Sound □Touch □Food Textures □Fabric/Clothing □ Other._____

Does your child exhibit any of the following sensory seeking behaviors? Check all that apply.

□Chewing on Clothing □Licking others □Biting without wish to harm others

□Need for deep pressure □Need for excessive contact □Other_____

Educational History:

Name of School:_____School District:_____

Current Grade in School:_____ Average Grades (ie., A, C):_____

□Private □Public □Home School □Cyber School □Other_____

Do you have concerns regarding your child having learning difficulties? □No □Yes

❖If you have no concerns regarding learning difficulty, then skip to Emotional/Behavioral History❖

Areas of academic strength: _____

Areas of academic difficulty:_____

If your child has an Individualized Education Program (IEP) or 504 Accommodation Plan, please state the reason for this: _____

Has your child been diagnosed with a Learning Disability? □No □Yes. Describe:_____

Is your child pulled out for learning support? □ No □ Yes. If so, for which subject (s)?_____

Has your child ever had to repeat a grade □No □Yes. If so, which grade and why?_____

Is you child currently receiving any of the following supports? (Check all that apply and indicate how often, where and when these are provided (school, privately)

□ Physical Therapy _____ □ Speech Therapy _____

□ Occupational Therapy _____ □ Other_____

Emotional/Behavioral History:

Do you have any concerns regarding your child's emotions or behavior? □No □Yes.

Describe:_____

❖ If you have no Emotional or Behavioral concerns, then skip to Sleep & Dietary History ❖

Do you have any concerns about managing your child's behavior? □No □Yes. Describe:_____

Disciplinary Methods Tried	Efficacy of Disciplinary Method

Has your child ever seen a behavioral specialist, counselor, or psychiatrist? □No □Yes.

Explain.

Does your child exhibit any of the following behavioral concerns?

□ Temper Tantrums □ Aggression □ Oppositional/ Defiant Behavior □ Hyperactive

□ Impulsive □ Inattentive □ Other

Explain:

Does your child experience any of the following? Check all that apply.

□ Anxiety □ Sadness/ Depression □ Obsessive thoughts □ Compulsive behavior

□Fears/Phobias □ Other

Explain:

Has your child ever been given a prior Psychiatric Diagnosis: □No □Yes

Explain.

Has your child previously taken medication to manage mood, emotions, or behavior? □No □Yes
If so, please provide details below:

Medications	Dates	Response to Medications

Sleep History:

Does your child experience any of the following?

□ Trouble falling asleep □Intermittent awakening during the night □Trouble waking up in the morning

□ Excessive Tiredness during waking hours □Bedwetting □Need to co-sleep (with parent, sibling, etc.)

Sleep pattern may impact your child's health. Please describe your child's sleep pattern during a typical academic school year.

	WEEKDAYS	WEEKENDS
Time of Waking Up		
Time No Longer Tired in AM		
Time Getting Into Bed		
Time Actually Falling Asleep		
If tired during the day, at what times and for how long?		
If night time awakenings occur, please note suspected cause (snoring, urination), frequency & duration		

Does your child seem to have trouble catching his/her breath while sleeping? □No □Yes.
If your child snores, are you concerned that your child's snoring may disrupt his/her sleep? □No □Yes.
Has your child ever had a sleep study? □No □Yes. Results: _____

Dietary History:

Does your child have any food restrictions or allergies? Explain._____

_____

Does your child follow a specialized diet? Explain._____

Social History:
Main language(s) spoken in the home:_____

Parents/Other:

1. _____
   Name Relationship to Child Profession
2. _____
   Name Relationship to Child Profession

Marital status: □ Married □ Never Married □ Separated □Divorced

Other pertinent caregivers/ details:

If your child has siblings, please list their names and ages: _____
_____

Please list all individuals living in the home, indicating their relationship to your child. Please describe any important specifics you would like to share regarding living arrangements/custody issues.

_____
_____
_____

Please list child's personal strengths: _____
_____
Please list child's favorite activities/interests: _____
_____

Family History:

Please indicate if any other family members have had any of the following:

Medical Diagnoses	Yes	No	Which Relative?	Maternal Side	Paternal Side
Cardiac/ Heart Disease					
Bleeding or Clotting Disorder Explain:					
Thyroid Disease					
Diabetes					
Cancer					
Stroke or Intracranial Bleed Explain:					

Neurological Diagnoses	Yes	No	Which Relative?	Maternal Side	Paternal Side
Delay in Speech					
Delay in Motor Skills					
Learning Disability					
Tic Disorder/Tourette					
Seizures/ Epilepsy					
Headaches/Migraines					
Attention Deficit /Hyperactivity					
Autism					
Intellectual Disability					
Neurological Regression/ Loss of Prior Skills					
Genetic/ Congenital Disorders					
Psychiatric Diagnoses	Yes	No	Which Relative?	Maternal Side	Paternal Side
Anxiety					
Depression					
Bipolar Disorder					
Obsessive Compulsive Disorder					
Schizophrenia/ Psychosis					

Other comments regarding family history:

Review of Symptoms: (Please circle any symptoms your child has exhibited over the **past week**)

System				
Constitutional	Weight loss/gain (circle which)	Fever	Fatigue	□ No current concerns Other:
Ophthalmologic	Visual changes	Eye pain	Blurred vision	□ No current concerns Other:
Ears, Nose, Mouth, Throat	Sore throat	Ear infection	Hearing difficulties	□ No current concerns Other:
Cardiovascular	Heart racing	Heart skipping beats	Chest pain	□ No current concerns Other:
Respiratory	Wheezing	Shortness of breath	Cough	□ No current concerns Other:
Gastrointestinal	Nausea/ vomiting	Constipation	Diarrhea	□ No current concerns Other:
Genitourinary	Bedwetting	Pain urinating	Urinary tract infection	□ No current concerns Other:
Musculoskeletal	Muscle pain	Joint pain	Joint swelling	□ No current concerns Other:
Integumentary/ Skin	Eczema	Rash	Itchy skin	□ No current concerns Other:
Neurological	Headache	Feeling faint	Tics	□ No current concerns Other:
Psychiatric	Sadness	Anxiety	Mood swings	□ No current concerns Other:
Endocrine	Excessive thirst	Excessive urination	Poor physical growth	□ No current concerns Other:
Hematologic/ Lymphatic	Lymph node swelling	Easy bleeding	Easy bruising	□ No current concerns Other:
Allergic/ Immunologic	Itchy eyes	Sneezing	Runny nose	□ No current concerns Other:

The information above is complete and accurate to the best of my knowledge.

Parent/ Guardian Signature Relationship Date

The information above has been reviewed and formally discussed in depth with the family.

Physician Signature Date

Rev. 12/31/18 br