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PEDIATRIC NEUROLOGICAL QUESTIONNAIRE

1. Child's Name: ______________________________

2. Date of Birth: ______________________________

3. Age: _____year/_____ months

4. Allergies: _____ Food/______ Drug(s)

5. Name and address of primary physician: ______________________________

   ____

   Who referred you? (If other than your primary physician): ______________________________

6. What problem(s) or question(s) do you wish to have evaluated?

   ____

   ____

   ____

7. For PDD/Autism Patients:

   Age of speech regression: ______________________________

   Nonverbal skills (i.e., pointing): ______________________________

   Type of toy play (appropriate? Imaginative? Lines things up?): ______________________________

   ____

   Sleep patterns: ______________________________

8. For Attention-deficit/hyperactivity disorder evaluation:

   Age first concerned? ______________________________

   Specific school issues: ______________________________

   Social problems: ______________________________

   Grades/Academic performance: ______________________________

   Resource or other school assistance: __________ Yes __________ No

9. For headache patients:

Frequency: ____________ per month   Duration: ____________________

Alleviated with: ____

Describe pain: ____
(location, intensity)

10. For seizure patients:

Describe event: ____

____

Loss of awareness: ____________ Yes ____________ No

Frequency: ____________ per month

Medications tried: ____

11. Test Performed:

EEG: Where: ______________________________ When: ____________

Abnormal/Normal/Office/Overnight   Results:

CT: Where: ______________________________ When: ____________

Abnormal/Normal/Office/Overnight   Results:

MRI: Where: ______________________________ When: ____________

Abnormal/Normal/Office/Overnight   Results:

EKG: Where: ______________________________ When: ____________

Abnormal/Normal/Office/Overnight   Results:

Hearing Test: Where: ______________________________ When: ____________

Abnormal/Normal/Office/Overnight   Results:

Neuro-psychological testing: Where: ______________________________ When: ____________

Abnormal/Normal/Office/Overnight   Results:

Genetic and chromosome: Where: ______________________________ When: ____________

Abnormal/Normal/Office/Overnight   Results:

12. List current and past medications (dosage & strength):

a.______________________________ d.______________________________
b.______________________________ e.______________________________
c.______________________________ f.______________________________

13. Child's Birth History:

    A. Hospital Name: ____

    B. Adoption Service: ____

    C. Age Adopted: ____________

    D. Pregnancy was: Normal _________ Short by ______ weeks/Overdue by ______ weeks

    E. Delivery was: Normal ____________ Breech ___________ Cesarean Section ____________
    Induced ____________ Vacuum ___________

    F. Baby's Birth Weight: ______lbs_______oz

    G. Apar Scores of baby at birth (if known): __________________________

    H. Pregnancy Complications: ____

    I. Delivery Complications: ____

    J. Newborn complications: ____

    Seizures ________________

    Jaudice _________________

    Other ____

14. Early Infant Developmental History: Please indicate the month that each skill was attained:

    A. Smiled _______________
    B. Sat without support _______________
    C. Crawled _______________
    D. Walked alone _______________
    E. Spoke first word _______________
    F. Spoke in short phrases _______________
    G. Toilet trained _______________
    H. Rode tricycle _______________
    I. Rode bicicle _______________
    J. Tied shoelaces _______________

    Did you ever feel that your child's speech development was slow or difficult to understand during the first three years? __________ Yes __________ No

    Did you ever feel that your child's motor skills (gross motor/fine motor) were delayed? __________ Yes __________ No

    Therapy received: OT __________ PT __________ ST __________ Where? ________________

15. Medical History

A. List any hospitalizations:
1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

B. List any surgeries:

1. ______________________________
2. ______________________________
3. ______________________________

C. Head Injuries: ______________________________

D. Seizures with fever: ______________________________

E. Chronic ear infections: ____________ Yes ____________ No

F. Other major medical problems: ______________________________

16. Family History — Medical Problems

A. Mother of patient ______________________________
B. Father of patient ______________________________
C. Brother(s)of patient: age _______ ______________________________
D. age _______ ______________________________
E. age _______ ______________________________
F. age _______ ______________________________
G. Sister(s)of patient: age _______ ______________________________
H. age _______ ______________________________
I. age _______ ______________________________
J. age _______ ______________________________
K. Are parents separated or divorced?: ____________ Yes ____________No ____________
L. Primary Caregiver: ______________________________
M. Are there any family members or relatives of the family with any of the following medical problems?:
1. Seizure disorder? __________ Yes __________ No
2. Mental retardation? __________ Yes __________ No
3. Learning disabilities? __________ Yes __________ No
4. Tourette's syndrome? __________ Yes __________ No
5. Migraine headaches/Chronic headaches?
   a. Migraine __________Yes __________ No
   b. Chronic __________ Yes __________ No
6. Muscle diseases? __________Yes __________ No
7. Depression or psychiatric illnesses? ________ Yes ________ No
8. Other illness (explain):
____
____
____
____