Child Neurology SOLUTIONS

PREFERRED PHARMACY NAME: _____

Address: _____ Phone #: _____

City: _____ State: ____ Zip: _____

Date form completed: _____Person completing form _____

If you have any questions about the form please call the office at (651) 356-6080

I. IDENTIFYING INFORMATION

NAME OF CHILD: _____Date of Birth: _____

Sex: □ M □ F Age: Years_____ Months _____

Reason for Consultation: _____

II. WHY IS YOUR CHILD BEING SEEN TODAY?

III. DETAILS ABOUT THIS PROBLEM

How long has your child had this problem? _____

Is the problem…. Getting better? Coming and going? Getting worse? (circle the one that applies)

What have you tried to help? (everything including medications, herbal remedies, supplements, acupuncture, chiropractic, etc) Please give doses and * those that you think helped.

_____

_____

_____

_____

Who has your child seen for this problem? _____

What workup has your child had? (bloodwork, imaging, other) _____

_____

What medications have been tried so far for this problem? _____

_____

Is a neurologist currently following your child? ☐Yes ☐ No If yes, what is their name? _____

What medications is your child currently on? (Include vitamins & herbal remedies)
(Use the 4th sheet if necessary)

Name of Medication	Dose	Times of Day

IV. PREGNANCY HISTORY

Was this baby full-term or premature? □ Yes □ No If premature, how early? _____

How many pregnancies have you had? _____

Have you had any:

Miscarriages? □ Yes □ No

Stillbirths? □ Yes □ No
Multiple Pregnancies? □ Yes □ No

Were you prescribed any medications during your pregnancy with this child □ Yes □ No
Please list _____

Were any of the following used during this child's pregnancy?
Nonprescription (street) drugs □ Yes □ No
Alcohol □ Yes □ No
Cigarettes □ Yes □ No

Any problems with this pregnancy? □ Yes □ No If no, skip to Labor and Delivery below
Describe: _____

_____

Was there a time during pregnancy when your baby stopped moving or moving as much? □ Yes □ No

LABOR AND DELIVERY
Birth weight: _____Length: _____ Apgar score : _____

Were there any problems with labor or delivery? □ Yes □ No If yes, please describe _____

_____

CONDITION OF THE BABY AT BIRTH
Did your baby cry right away? □ Yes □ No Have any breathing difficulties? □ Yes □ No
Did your baby have a bowel movement before being born? □ Yes □ No
Did they have their umbilical cord wrapped around the neck? □ Yes □ No
Were there other complications? □ Yes □ No Describe if known: _____

NEONATAL CARE
Did your baby have any problems after they were born? □ Yes □ No If yes, please describe: _____

_____

How long was your baby in the hospital? _____

V. INFANCY
During the first few months, was your baby
limp/floppy? □ Yes □ No
stiff? □ Yes □ No
very irritable □ Yes □ No
difficult to feed? □ Yes □ No

During the first year of life, did your baby:
have difficulty sleeping? □ Yes □ No
have excessive crying? □ Yes □ No
fail to grow or gain weight? □ Yes □ No
show any unusual movements of arms, legs, or head? □ Yes □ No

VI. DEVELOPMENTAL HISTORY
Do you think your child is developing normally? □Yes □ No If yes, when did you first become worried about this? _____
Do you have concerns about their:
Social interactions □ Yes □ No Fine motor skills □ Yes □ No
Language □ Yes □ No Gross motor skills □ Yes □ No

Is your child losing skills in any area? Which ones and over what period of time? _____

_____

When did your child first (months or years)
Smile ____ Lifted head _____ Drank from a cup _____
Coo _____ Rolled over _____ Show a hand preference _____ □ right □ left
Mama/Dada _____ Sat _____ Rode tricycle _____
First words _____ First steps _____ Rode bicycle _____
2 word sentences _____ Walk _____ Toilet trained- bladder _____ bowel _____

VII. REVIEW OF SYSTEMS

Neurologic Review of Systems

Does your child have problems with any of the following? (check all that apply):

□ Seizures (convulsions)
□ Change in behavior or personality
□ Hearing or vision
□ Headaches or migraine (circle)
□ Sleeping
□ Tics or unusual movements
□ Dizziness, fainting
□ Excessive drooling
□ Swallowing or choking (circle)
□ Clumsiness, frequent falls, difficulty walking (circle)
□ Movement problems requiring the use of special shoes, splints, braces or a wheelchair or specialized equipment (e.g. walker, stander, etc.)
□ Sensation including numbness or tingling
□ Toe walking
□ Weakness or decreased endurance (circle)
□ Changes in bowel or bladder function
□ Any trouble with vision? Date of last exam_____
□ Any trouble with hearing? Date of last examination _____

General Review of Systems

Does your child have problems with any of the following? (check all that apply):

□ General health (fevers, weight loss)
□ Anxiety or depression
□ Change in school performance
□ Abuse or neglect
□ Growth or hormone problems
□ Frequent colds, ear infections, pneumonia
□ Allergies
□ Recurrent wheezing, asthma
□ Skin (eczema, rash birth marks)
□ Vomiting, reflux, constipation, diarrhea
□ Heart or blood pressure problems
□ Kidney or bladder
□ Bleeding problems
□ Swollen or painful joints

Are any of the above problems progressive or ongoing? □Yes □ No If Yes, please circle the item(s) above

Are there family members with the same or similar problem(s)? □Yes □ No
If Yes, who & what?_____

Behavior

Does your child have any behavior problems? □Yes □ No If yes, please check all boxes that apply.

□ head banging	□ nail biting	□ body rocking
□ hand flapping	□ temper tantrums	□ thumbsucking
□ bedwetting	□ disruptive behavior	□ nightmares
□ breathholding	□ hyperactivity	□ inattention
□ self-injury	□ other behavior problems _____	

Next to each item checked add the following:

For severity: Mild = M; Moderate = Mod; Severe = S
For frequency: Daily = D; Weekly = W; Monthly = M
For location: Home = H; School = S; Both = B

CURRENT SCHOOL PLACEMENT/EARLY INTERVENTION PROGRAM

Name of school OR preschool: _____Current grade: _____

Has child ever repeated a grade? □ Yes □ No If Yes, which _____

Does your child have any learning problems? □ Yes □ No If Yes, are these problems with:

Speech □ Yes □ No

Reading □ Yes □ No

Writing □ Yes □ No

Math □ Yes □ No

Have they ever had psychological or educational testing? □ Yes □ No

When? _____ Who did this testing & where was it done? _____

Does your child have an IEP (Individualized Educational Plan)? □Yes □ No

Does your child receive: (check all that apply)	Frequency/week	in school	outside of school (if so, where?)
Occupational therapy	_____	_____	_____
Physical therapy	_____	_____	_____
Speech/Language therapy	_____	_____	_____
Counseling	_____	_____	_____

VIII. PAST MEDICAL HISTORY

Has your child had any serious illnesses or injuries so far?

_____

_____

_____

_____

Does your child have any chronic medical problems?

_____

_____

_____

_____

Has your child had any hospitalizations or surgeries?

_____

_____

_____

Does your child use any special equipment? □ Yes □ No

_____

_____

_____

Has your child had all their immunizations? □ Yes □ No

Any medication allergies (Specify) □ Yes □ No _____

_____

IX. FAMILY HISTORY

	Mother	Father
Age:	_____	_____
Right or left-handed?	□ Right □ Left	□ Yes □ No
Ethnic Background:	_____	_____
Medical problems:	_____	_____
	_____	_____
	_____	_____
	_____	_____

Are the parents of this child related by blood? (i.e. cousins, etc.) □ Yes □ No

SIBLINGS:

Initials	Age (yrs & mos)	Sex (M/F)	Relationship to Patient: (Full/Half/Adopted/Step)	Health	Grade in School
1.					
2.					
3.					

4. _____
5. _____

Check any medical problems in other family members (siblings, grandparents, cousins, etc). Please note which family member(s) has(have) the problem.

- ❑ Seizures with or without fever
- ❑ Headaches or migraines
- ❑ Tics or other movement problems
- ❑ Slow development
- ❑ Learning disabilities
- ❑ Attention deficit disorder
- ❑ Mental retardation
- ❑ Alzheimer's disease
- ❑ Stroke
- ❑ Psychiatric disease (depression, etc.)
- ❑ Deafness
- ❑ Coordination problems
- ❑ Nerve or muscle disease
- ❑ Cerebral palsy
- ❑ Diabetes (sugar too high)
- ❑ Allergies
- ❑ Alcoholism
- ❑ Blindness
- ❑ Early death
- ❑ Chromosome problem
- ❑ Blood clotting problems
- ❑ Fainting spells
- ❑ Cancer
- ❑ Asthma
- ❑ Thyroid disease
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Miscarriages or spontaneous abortion
- ❑ Other _____
- ❑ Other _____

- ❑ Birth defects

X. SOCIAL HISTORY

Marital Status: □ Married □ Single □ Separated □ Divorced

Child lives with: _____

Who is involved in the caretaking of this child? _____

Thank you for completing this questionnaire!

PLEASE FAX COMPLETED FORM TO (651) 356-8486 or BRING TO YOUR CLINIC VISIT