GOLISANO
CHILDREN'S HOSPITAL

UNIVERSITY of ROCHESTER
MEDICAL CENTER

Division of Child Neurology Intake Questionnaire

This form is to be filled out by parents or guardians. Please bring it with you to the appointment.
Other items to bring: CT scan's, MRI's, Report Cards, School testing, Behavior rating scales.
(A CD of images can be requested from the hospital or facility where the studies were performed)
Thank you for taking the time to answer the questions.

Child's Full Name:____ Age:__________
Birth Date:______________________________
Address:____
Mother's Name:_____________________________________ Phone (home):__________________
(cell/work):___________________
Father's Name:_____________________________________ Phone (home):___________________
(cell/work):___________________
Primary Care Provider:______________________________ Phone:_________________________

Is your child? [ ]right handed [ ]left handed [ ]no hand preference [ ]ambidextrous
Did your child establish a hand preference (right or left handed) before age 2? [ ] no [ ] yes

Current Concerns

Please describe briefly your reasons or concerns for bringing your child here to be evaluated.
We will talk this over at length during the visit.

____
____
____
____

Please list the names & addresses of any other specialists or agencies involved in your child's care:

____
____
____

Please describe any other concerns or questions you want to be sure we are aware of:

____
____
____

MEDICATIONS

Current Medications	For what diagnosis? (seizure, headache, ADHD, etc)	Pill size (mg) or concentration (mg/ml or mg/5ml)	*Dose (mg)*	Times per day?	Side Effects

Past Medications	For what diagnosis?	Dose (mg)	*Times per day*	Approximate Start & End Date	Side Effects

Does your child have any history of the following problems?
Please check all that apply and indicate age of onset:

_____Staring spells_____Seizures____Convulsions__________Headtrauma/concussion
_____Headache_____ Dizziness_____ Fainting_____ Vision problems_____ Hearing problems
_____Heart problem including: murmur/dizziness/fainting
_____Asthma/Wheezing/Other breathing problems_____ Drooling_____ Constipation/Diarrhea
_____High or Low muscle tone_____ Weakness_____ Stroke_____ Tremor
_____Birthmarks/Patches of brown/red skin _____ADHD_____ Anxiety_____ Bipolar
_____OCD _____ODD(oppositional defiant disorder)_____CD(conduct disorder)_____
_____Difficulty falling asleep_____Difficulty staying asleep____ Snoring_____Teeth clenching/grinding
_____Getting along w/children his/her age_____ Learning/Making progress in school
_____Thyroid problems/growing too fast or slow _____Easy bruising, bleeding, bloody nose

____
____
____
____
____

Any Allergies?: [ ]seasonal [ ]environmental [ ]animals [ ]latex [ ] contrast dye
[ ] medications, please list:____

BIRTH HISTORY/PAST HISTORY

Any complications of pregnancy? Please circle: Bleeding Illness Falls Other
Describe:____

List any medications, drugs, alcohol or cigarette use during the pregnancy:
____

Were there any interventions/problems with your labor and delivery with this child?
Forceps? Vacuum extraction? C-section? Emergency C-section?
Describe:____

Was this child born near due date, earlier than expected or after his/her due date?
Near due date__________ How many weeks early?__________ How many weeks late?____________
Your child's birthweight: _____pounds_____ ounces **or** _____kilograms

Did this child have any problems during the first few weeks of life?
Breathing problems? Feeding problems? Jaundice? Light therapy? Extended Stay?
Describe:____

Did this child have any serious illnesses during the first year of life? High fevers? Hospitalizations?
Describe:____
____
____
____

DEVELOPMENTAL HISTORY

At what age did your child?
Sit up alone__________ Crawl__________ Pull up to standing__________
Walk unsupported__________ Say first word__________ Say a sentence with three words__________
Early Intervention was initiated__________ months/years Never__________

PAST MEDICAL HISTORY

	Date	Age	What	Hospital
Illness				
Surgery				
Hospitalization				

FAMILY HISTORY

Is your child adopted? [ ]YES [ ]NO   Are Parents Adopted? [ ]Mother [ ]Father

Does anyone related to your child have the following disorders?
(Include parents, siblings, aunts, uncles, cousins or grandparents)

Disorders	Circle one	Circle one	Relationship to Child
Seizures	YES	NO	
Headaches/Migraine	YES	NO	
Fainting/Motion sickness	YES	NO	
Intellectual Disability	YES	NO	
Learning Problems	YES	NO	
ADHD	YES	NO	
Tics/Tourette's	YES	NO	
Degenerative Disease	YES	NO	
Other Neurologic Problems	YES	NO	
OCD, Depression, Anxiety Bipolar, Schizophrenia	YES	NO	
Bleeding/Clotting Disorder	YES	NO	
Heart attack/ stroke/ arrhythmia/sudden death before age 35	YES	NO	

CHILD'S BROTHERS AND SISTERS

Name	Age	Any Health/Learning Problems

SCHOOL

School Name____Grade_________________
Phone Number____________________________________School Nurse____________________________
Address____
Special Services (please circle): OT PT Speech Special ED IEP 504 plan
Class Size (please circle): regular 15:1:1 12:1:1 8:1:1 other
Has your child had any psychoeducational or neuropsychological testing? If yes, when and where?
____
____
____