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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. Who referred patient? _____

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 disorder evaluation:
Age first concerned? _____
Specific school issues: _____
Social problems: _____
Grades/Academic performance: _____
Resource or other school assistance: _____ Yes _____ No

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: _____

G. Apgar Scores of baby at birth (if known): _____

H. Pregnancy Complications: _____

I. Delivery Complications: _____

J. Newborn Complications: _____

Seizures _____

Jaundice _____

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 words _____

F. Spoke in short phrases _____

G. Toilet trained _____

H. Rode tricycle _____

I. Rode bicycle _____

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. _____
5. _____

B. Previous 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

A. Mother of patient Medical problems _____

B. Father of patient _____

C. Brothers of patient: age _____ _____

_____ _____

D. Sisters of patient: age _____ _____

_____ _____

_____ _____

E. Are parents separated or divorced: Yes _____ No _____

G. Primary caregiver: _____

H. 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/headaches? Yes _____ No _____
6. Muscle diseases? Yes _____ No _____
7. Depression or psychiatric illnesses? Yes _____ No _____
8. Other illnesses (explain) _____

