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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: \_\_\_\_\_

\_\_\_\_\_

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



**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 \_\_\_\_\_

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 \_\_\_\_\_ \_\_\_\_\_

age \_\_\_\_\_ \_\_\_\_\_

age \_\_\_\_\_ \_\_\_\_\_

age \_\_\_\_\_ \_\_\_\_\_

D. Sisters of patient: age \_\_\_\_\_ \_\_\_\_\_

age \_\_\_\_\_ \_\_\_\_\_

age \_\_\_\_\_ \_\_\_\_\_

age \_\_\_\_\_ \_\_\_\_\_

E. Have/are parents separated or divorced: Yes \_\_\_\_\_ No \_\_\_\_\_

F. Primary caregiver: \_\_\_\_\_

G. 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? Yes \_\_\_\_\_ No \_\_\_\_\_

6. Muscle diseases? Yes \_\_\_\_\_ No \_\_\_\_\_

7. Depression or psychiatric illnesses? Yes \_\_\_\_\_ No \_\_\_\_\_

8. Other illnesses (explain) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_