PEDIATRIC NEUROLOGY QUESTIONNAIRE

Date: ___ ___ / ___ ___ / ___ ___
dd mm yy

Name:			Healthcare #:
DOB: (DD-MMM-YY)	Age:	Sex: ☐ Male ☐ Female	
Street Address:			City:
Province:	Postal Code:		
Home Phone:	Mobile Phone:		
Extended Health Insurance Provider:			
Height: ☐ cm ☐ in	Weight: ☐ kg ☐ lbs		Grade in school (if applicable):
Racial/Ethnic Background (please circle): 1.) American Indian 2.) Asian-American 3.) African-American 4.) Hispanic 5.) White/not Hispanic 6.) Middle-Eastern 7.) Other or unknown			
Referring Physician:		Family Physician:	
Other Healthcare Providers:			

Name of Person Answering Questions: _____.

Relation to Child: _____.

Instructions:

Please answer the following questions. If you are not sure, you may leave the answer blank. Please write legibly. This questionnaire is not intended to be stressful, so please don't worry if you're not sure about some of the answers. We will review your answers during the appointment.

Questions:

What is the reason for referral to Pediatric Neurology by your physician?

_____

What is your main concern that you would like addressed at the appointment?

_____

What other concerns do you have that may be relevant to this appointment? (briefly)

_____

_____

_____

Please tell me about your child's general health:

1. Were there any issues during pregnancy? Yes / No
2. Were there any issues during delivery? Yes / No
3. What was the mode of delivery? C/section (why?) / Vaginal
4. What was the birth weight? _____
5. Did your child stay in the NICU? Yes / No
6. Was your child breast fed or formula fed? BF / Formula
7. Does your child have any other medical conditions? Yes / No

Please elaborate if you answered 'yes' to any of the above.

_____

_____

_____

_____

_____

_____

List the medications your child currently takes (dose and schedule), including over the counter supplements (e.g. Vitamin D, melatonin, etc):

_____

_____

_____

_____

_____

Please tell me about your family history:
Child's siblings – first name, age, general health, medical conditions

_____

_____

_____

_____

Child's mother – first name, age, health conditions (including migraines/headaches, fainting spells, etc), education, occupation

_____

_____

_____

Child's father – first name, age, health conditions, education, occupation

_____

_____

Does anybody in the family, including the siblings of parents and grandparents, have any of the following?

Autoimmune condition (e.g.: thyroid disease, multiple sclerosis, celiac disease, Lupus, etc)

Seizures

Fainting spells (syncope)

Motion sickness

Developmental delay

Miscarriages or early neonatal deaths

Other neurological conditions not listed above (please elaborate)

_____

_____

Is your child immunized?	Y	/	N
Does your child have any drug allergies?	Y	/	N
Any other allergies (ex. food, environmental)	Y	/	N

_____

_____

_____

Please tell me about your child's development (<u>answer Version 1 or Version 2 depending on age</u>).

<u>Version 1. If your child is less than 7 years of age</u> and/or does not attend school, please answer the following.
Only answer what's appropriate for the child's age; you may leave the remainder blank. If you don't remember the exact time, try to approximate or leave a question mark. **For yes/no questions, write Y or N.**

1. **<u>Gross motor:</u>** - when did your child first roll over?
   - when did your child sit on his/her own?
   - when did he/she walk independently?
   - can your child throw a ball? kick a ball? catch a ball?
   - how does your child climb up stairs?
   - when did he/she start riding a tricycle? a bicycle?

2. **<u>Fine motor:</u>** - when did your child start grabbing at objects?
   - does your child feed himself/herself with hands? utensils?
   - does your child doodle?
   - can he/she draw a circle? a square? a triangle?
   - can he/she write his/her own name?
   - can your child dress independently? undress?
   - can your child do buttons? zippers?

3. **<u>Language:</u>** - at what age was your child's first word?
   - when did he/she start putting 2 words together?
   - when did he/she begin speaking in full sentences?
   - how intelligible is the speech (%) to you? to strangers?
   - was Speech Language Therapy ever required?
   - can your child follow 1-step commands (e.g. put your shoes on)?
   - 2-step commands? (e.g. go to the kitchen and bring me the red cup)?
   - when you read books to your child, does he/she understand and follow the story?
   - can he/she describe/explain the story back to you?

4. **<u>Cognitive:</u>** - does your child play peek-a-boo? - does he/she know colours?
   - does he/she look for dropped items? - does he/she know the alphabet?
   - is he/she potty trained?
   - does he/she know body parts?

5. **<u>Social:</u>** - when did your baby first smile at you?

- is your child interested in playing with other children?
- is he/she socially involved? or prefers to be alone?
- is he/she shy or outgoing?

Version 2. If your child is over 7 years of age and/or attends school (grade 1 and above), please answer the following.

1. Were there any concerns about development? Y / N
If yes, please elaborate:

_____

_____

_____

_____

_____

2. Does your child attend a regular classroom? Y / N

3. Does your child have an IPP? Y / N

4. What grade does your child attend?

5. What is the approximate grade point average?

6. Any particularly difficult subjects?

Other comments or questions you may have:

_____

_____

_____

Thank you for your time.