

Associated Neurological Specialties

Robert M. Cain, M.D. Jill E. Heytens, M.D. George A. Petroff, M.D.

Pediatric Medical History/Developmental Questionnaire

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Your Name: _____

Relationship to Patient: _____

Child's Primary Care Doctor and phone number:

Other doctors who should receive a copy of our report with phone numbers:

1. Is the child adopted? **Yes** **No** If yes, age when adopted _____2. Are parents married? **Yes** **No** Separated? **Yes** **No** Divorced? **Yes** **No**3. **Please list all other children in the family:**

Name	Age	Grade
1.		
2.		
3.		
4.		
5.		

4. **Child's Problem:**

5. Do you see this child as being hyperactive or as having problems with attention and concentration?**Yes** **No** If **yes**, please explain.6. Has this child received treatment for ADHD?**Yes** **No** If **yes**, please explain.

7. Do any other family members (e.g. mother, father, sister, brother, aunt, uncle, etc.) suffer from inattentiveness/ hyperactivity or some other type of psychological, emotional, learning problem and/or nervous disorder?

Yes No

8. Is your child taking any type of medication at this time?

Yes No If yes, please write the name(s) and dosage(s).

9. Current Medications:

<u>Medication</u>	<u>Dosage</u>	<u>How Often</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. List Any Allergies or Other Problems Caused By Medications

11. Please list any unusual and/or traumatic event in this child's life, which you feel may have affected his or her development and ability to function (for example, birth of a sibling, death in the family, divorce, illness, moves, etc.)

12. Has your child had any of the following tests?

<u>Test</u>	<u>Date</u>	<u>Where</u>	<u>Results</u>	
MRI	_____	_____	Normal	Abnormal
CT	_____	_____	Normal	Abnormal
EEG	_____	_____	Normal	Abnormal

Other Tests:

PAST MEDICAL HISTORY**BIRTH HISTORY:**

1. Was your child born early or after nine months of pregnancy? **Early**____ **Full Term**_____

2. If early, how many weeks gestation?_____ **Birth Weight**_____

3. Mother's age when child was born:_____

4. Was a C-section performed? **Yes**_____ **No**_____

5. Were there complications during the pregnancy or at delivery? **Yes**_____ **No**_____

If so, what was the complication?_____

6. Did the baby come home with you from the hospital? **Yes**_____ **No**_____

If not, how long did the baby stay in the hospital?_____

7. Were there any problems with your child during delivery or within first few days after birth (e.g. cardiopulmonary distress during delivery, cord around neck, difficulty breathing, cyanotic, jaundiced, seizures, etc.)? **Yes** **No** If yes, please explain. _____

8. Does your child have any birth defects? **Yes** **No** If yes, please describe._____

9. Has your child ever been hospitalized or had any surgeries?

Age_____ Reason_____

Age_____ Reason_____

Age_____ Reason_____

10. Has your child had all of his/her immunizations required for his age?

Yes_____ **No**_____ **Not Sure**_____

INFANT HEALTH AND TEMPERAMENT

11. During the first 24 months, was or did your child experience any of the following:		
Difficult to feed	Yes	No
Difficult to get to sleep	Yes	No
Colicky	Yes	No
Difficult to put on a schedule	Yes	No
Difficult to keep busy	Yes	No
Overactive, in constant motion	Yes	No
Very stubborn, challenging	Yes	No
Alert	Yes	No
Cheerful	Yes	No
Affectionate	Yes	No
Sociable	Yes	No
Easy to comfort	Yes	No

12. Has your child ever had any of the following? If so, when?

Seizure: With Fever _____	Without Fever _____
Head Injury _____	Loss of Consciousness _____
Severe Headache _____	Hearing Problems _____
Vision Problems _____	Frequent Day-dreaming _____
Problems Sleeping _____	Daytime Sleepiness _____
Unexplained Vomiting _____	Loss of Balance _____
Weakness of Extremities _____	Paralysis of Extremities _____
Numbness/ Tingling _____	Double Vision _____

13. Does your child have problems with any of the following?

Asthma _____	Other breathing Issues _____
Nose or Throat _____	Thyroid _____
Heart _____	Stomach Pain or Digestive _____
Changes in Bowel or Bladder Function _____	
Weight Loss or Gain _____	Swollen Lymph Nodes _____
Rashes or Skin _____	Bruising or Bleeding _____
Motor coordination _____	

HEALTH HISTORY:

1. What is your child's present health status? **Poor Fair Good**

2. At any time, has your child had the following:

a. <u>Speech or language problems</u>	Yes	No
b. <u>Chronic ear infections</u>	Yes	No
c. <u>Hearing difficulties</u>	Yes	No
d. <u>Eye or vision problems</u>	Yes	No
e. <u>Appetite problems (overeating or under-eating)</u>	Yes	No
f. <u>Sleeping problems (falling asleep, staying asleep)</u>	Yes	No
g. <u>Gross motor difficulties, clumsiness</u>	Yes	No
h. <u>Fine motor difficulties (utensil use, buttoning, handwriting)</u>	Yes	No
i. <u>Visual Perception/ Visual Motor Integration Difficulty</u>	Yes	No
j. <u>Auditory Processing Disorder</u>	Yes	No
k. <u>Tactile Defensiveness (to touch, clothing tags, etc.)</u>	Yes	No
l. <u>Sensory Integration Issues (body awareness, coordination, etc.)</u>	Yes	No

3. Has your child ever been seen by a specialist (eye doctor, heart doctor, lung doctor, etc.)?

Yes No If yes, who? _____

DEVELOPMENT:

4. At what age did your child learn the following skills?

Rolling Over _____ Sitting _____ Crawling _____

Walking _____

First Words _____ Speaking in Sentences _____

Toilet Trained **Bladder:** _____ **Bowel:** _____

Has your child ever received any physical therapy? _____

Has your child ever received any speech therapy? _____

If so, how often does he/she get therapy? _____

If so, where? _____

EDUCATIONAL HISTORY

5. Name of school: _____ Grade: _____

6. Type of classroom placement (regular, resource room, special education, etc.) _____

7. Is your child having difficulty at school? **Yes No**

8. Does your child have difficulty with any of the following:

a. Reading	Yes	No
b. Spelling	Yes	No
c. Writing	Yes	No
d. Math	Yes	No
e. Following Instructions	Yes	No
f. Completing assignments	Yes	No

9. Has your child failed any subjects? Yes No If yes, which ones?

10. Has your child repeated any grades? Yes No If yes, which one and what was the reason?

11. Please list or discuss any other school problems:

FAMILY

1. Who in the family has had any of these problems? (Please include parents, brothers, sisters aunts, uncles, grandparents, and cousins.)

Seizures _____ Learning Disabilities _____

Migraines or Headaches _____ Genetic Diseases _____

Depression _____ Bipolar Disorder _____

Autism _____ Attention Problems _____

Brain Tumor _____ Substance Abuse _____

Mental Retardation _____ Movement Disorder/ Tics _____

2. Are there any other medical problems that run in the family?

SOCIAL

3. Who lives at home with your child?

4. Are the parents: Married Divorced Never Married Separated

5. Parent's occupation:

Father: _____ Mother: _____

6. Is there any additional information you would like the doctor to know?

7. Are there specific questions you would like to address at this visit?
