ATTENTION NEW PATIENT!

ATTACHED IS THE NEW PATIENT PACKET FOR YOU TO FILL OUT COMPLETELY.

PLEASE BRING YOUR INSURANCE CARD, THIS PACKET AND A REFERRAL (IF YOUR INSURANCE REQUIRES ONE) TO YOUR SCHEDULED APPOINTMENT.

PLEASE **DO NOT** MAIL THIS BACK!

ALSO, IF YOU CANNOT MAKE YOUR APPOINTMENT, PLEASE CALL OUR OFFICE. WE DO HAVE AN OFFICE POLICY IF THE APPOINTMENT ISN'T CANCELLED WITHIN 24 HOURS OR THE PATIENT IS A **NO SHOW**, THERE IS A $50 CHARGE TO THE PATIENT (IF A MINOR, THE PATIENTS PARENTS ARE CHARGED)

UPON RESCHEDULING WE WILL ASK FOR A CREDIT CARD NUMBER OR CHECK TO FULFILL THIS $50 CHARGE. WE WILL NEED THIS PAYMENT BEFORE THE NEW APPOINTMENT IS MADE.

PATIENT PORTAL AUTHORIZATION

Dear Patient,

We are launching a new patient portal for our office. By signing up for the patient portal, you will be able to view your visit summaries and send non-urgent medical questions to our office staff. Please provide your email address so you can be signed up for the portal today.

Patient Name: _____

DOB: _____

Patient Zip Code: _____

Email Address: _____

□ Yes, sign me up for the patient portal.

□ No, I DO NOT want to participate in the patient portal.

For Office Use Only:

Date entered:_____

□ Accepted □ Declined

Initials: _____

Institute of Neurology
200 South Orange Avenue, Suite 165
Livingston, New Jersey 07039
Phone (973) 322-7580 Fax (973) 322-7505

PEDIATRIC PATIENT QUESTIONAIRE

Name:_____ Date: _____

Address: _____

City: _____ State:_____ Zip: _____

Home Phone: _____ Cell phone: _____

Sex: _____ Date of Birth: _____ Email: _____

Pediatrician's Name: _____ Phone: _____
Address: _____
Were you referred by your pediatrician? Yes/No If not, how were you referred?
_____ shall we send a report to your physician? Yes/No

Who is accompanying the child today? _____
Age of child _____ Right handed / Left Handed? Ambidextrous (circle one)

CHIEF COMPLAINT:
What brings you to this visit today?

_____

_____

How long have the symptoms been present? _____

NEUROLOGICAL SYMPTOMS:

Motor/Vocal tics	Yes/No	Impulsivity	Yes/No
Severe Headaches	Yes/No	Neck Pain	Yes/No
Fainting spells	Yes/No	Slurred Speech	Yes/No
Memory Difficulty	Yes/No	Double Vision	Yes/No
Hyperactivity	Yes/No	Numbness	Yes/No
Seizures	Yes/No	Unsteadiness	Yes/No
Severe head injury	Yes/No	Low back pain	Yes/No
Depression	Yes/No	Sudden visual loss	Yes/No
Inattention	Yes/No	Hearing loss	Yes/No
Dizziness	Yes/No	Stroke/TIA	Yes/No
Obsession or compulsion	Yes/No		

Have you ever consulted a neurologist for your child before? Yes / No
If so, what for?_____
Have you ever been hospitalized for a psychiatric or emotional problem?
Yes / No
Previous Studies / Date (Bring a copy of recent test and x-ray results)
Cat Scan head_____EEG_____Ultrasound of _____
MRI_____EKG_____Other_____

PAST MEDICAL HISTORY:

_____
_____
_____.

High blood pressure	Yes / No	Diabetes	Yes / No
Heart disease / murmur	Yes / No	Ulcer or Gastritis	Yes / No
Thyroid disease	Yes / No	Kidney problems	Yes / No
Cancer	Yes / No	Blood transfusion	Yes / No
Type_____		Lyme disease	Yes / No
Asthma	Yes / No	Hepatitis	Yes / No
Tuberculosis	Yes / No	Drug dependency	Yes / No
Pneumonia	Yes / No		

SURGICAL HISTORY: (included type and year)

_____
_____
_____.

OTHER HOSPITALIZATONS: (include reason and year)

_____
_____
_____.

MEDICATION:

_____
_____
_____.

PAST MEDICATIONS: (for epilepsy patients)

o Neurontin	o Klonopin	o Lamictal	o Sabril
o Depakote	o Ativan	o Topamax	o Dilantin
o Zonegran	o Valium	o Felbamate	o Tegretol
o Mysoline	o Primidone	o Keppra	o Trileptal
o Tiagabine	o Phenobarbital	o Others _____	

ALLERGIES TO MEDICATIONS: None_____

Penicillin _____Sulfa drugs _____Aspirin _____X-ray dye _____

BIRTH HISTORY:

Duration of pregnancy_____Type of delivery: (circle) Vaginal C-Section
Medications during pregnancy_____Birth Weight:_____
Apgar score: 1 min_____ 5 mins _____
Were there any complications with the pregnancy, delivery, or newborn period? If Yes, what were they? _____

DEVELOPMENTAL HISTORY:

Does your child have any impairment in (circle):*Gross motor skills
*Social skills *Fine motor skills *Speech / Language skills
Other_____
Does your child receive any: (circle) *Physical Therapy
*Occupational Therapy *Social Skills groups *Psychotherapy
*Speech skills *Visual Training

Motor:
Was there any concern about your child accomplishing the following milestones? (circle): *Head Control *Stood alone unassisted
*Walked unassisted *Sat alone *Tricycle *Crawled
*Bicycle *Turned over
Did your child walk by m18 months of age? Yes / No

Speech:
Difficulty with: (circle) *Drooling *Chewing *Swallowing
Spoke first words_____Spoke first phrases_____
Spoke complete sentences_____Is speech adequate for age? Yes / No
Did your child speak first words by 2 yrs of age? Yes / No
Did your child speak phrases or sentences by 3 yrs of age? Yes / No
Do you consider your child to understand directions and situations as well as any child his/her age does? Yes / No

Coordination:
Do you have any concerns about the following skills? (circle)
*Walking *Running *Handwriting *Shoelace Tying *Athletic Abilities

School:
Grade:_____School:_____

Special Ed: Yes / No

Rate your child with regard to school experiences, learning and/or adjustments in school:

	GOOD	AVERAGE	POOR
Nursery school	_____	_____	_____
Kindergarten	_____	_____	_____
Current Grade	_____	_____	_____

Describe any school issues: _____
Does your child receive any extra service in school? _____

Behavior:

Please circle any of the following that apple to your child's behavior:

*Cries easily *Underactive *Low frustration threshold *Temper outbursts

*Aggressiveness *Does not play well with peers *Sibling Rivalry

*Multiple fears *Others_____

Behavior Problems: (circle) Home School Both

Does your child eat well? Yes / No Does your child sleep well? Yes / No

Does your child display any of these symptoms to an extreme:

Fails to give close attention to details	Yes / No
Has difficulty sustaining attention	Yes / No
Does not seem to listen when spoken to directly	Yes / No
Does not follow through on tasks	Yes / No
Has difficulty organizing tasks	Yes / No
Reluctant to engage in tasks that require sustained mental effort	Yes / No
Loses things	Yes / No
Easily distracted	Yes / No
Forgetful	Yes / No
Fidgets	Yes / No
Leaves his/her seat inappropriately	Yes / No

Runs about or climbs excessively	Yes / No
Has difficulty playing and engaging in leisure activities quietly	Yes / No
Acts as if he/she is "driven be a motor," always " on the go"	Yes / No
Talks excessively	Yes / No
Blurts out answers before questions have been completed	Yes / No
Has difficulty awaiting his/her turn	Yes / No
Interrupts or intrudes on others	Yes / No

FAMILY HISTORY:

Mother: Age____ Age at pregnancy with patient_____
Any spontaneous abortions or miscarriages____Highest schooling_____

Occupation_____Medical Problems_____

School Problems (circle): *Learning *Speech *Behavior *Other_____

Father: Age_____Occupation_____
Highest schooling_____Medical Problems_____

Sibilings: Name Age Medical, Social, or Academic Problems

1._____ _____ _____
2._____ _____ _____
3._____ _____ _____

Circle any that apply that are not mentioned above:

Seizures/Epilepsy	Learning Disabilities	Brain Tumor
Migraines/Headaches	Parkinsons	Stroke
Tourette's Synd	Alzheimers	Depression
Muscle disease	Nerve disease	Diabetes
Mental illness	Multiple Sclerosis	Hypertension
Obsessive Comp. Dis.	Mental retardation	Heart disease
Schizophrenia/Bipolar	Speech/Language	ADHD

Other Serious Illness_____

SOCIAL HISTORY:

Living arrangements: Parents Mother Father Other_____

How many people are there in your household?_____

Are there frequent conflicts at home?_____

Where was your child born?_____

Adolescents Only:

Smoking: Yes / No Amount_____ When stopped?_____

Alcohol: Yes No Occasionally Daily amount?_____

REVIEW OF SYSTEMS: (circle any symptoms that apply) NONE

CONSTITUTIONAL: *Fever *Weight gain/loss *Night sweats *Extreme fatigue

SKIN: *Rash *Birthmarks (more than 5) *Skin cancer

EYES: *Eye pain *Wears glasses/contacts

ENT: *Ringing in ears *Sinus infection *Trouble swallowing *Pain swallowing *Grinding of teeth *Frequent nosebleeds

CARDIOVASCULAR: *Chest pain *Palpitations *Irregular beat *Murmur

RESPIRATORY: *Shortness of breath *Chronic cough *Wheezing

GASTROINTESTINAL:*Nausea *Vomiting *Constipation *Reflux *Blood in stool

GENITOURINARY: *Incontinence of urine *Pain when urinating

HEMATOLOGY: *Bleeding tendency *Anemia *Easy bruising

GYNECOLOGY: *Loss of menstrual period (excluding pregnancy) *Irregular menstrual periods

PSYCHIATRIC: *Depression *Anxiety *Hallucinations

MUSCULOSKELETAL: *Joint pain *Joint swelling *Muscle pain *Back pain

SLEEP: *Snoring *Pausing in breathing
*Discomfort/Restless leg *Insomnia

DIET: Any special diet?_____

TRAVEL: Where and when has your child traveled in the past 2 years?_____
_____.

Is your child toilet trained? Yes / No
If so, at what age was your child toilet trained? For Day_____Night____
_____.

Have we left anything out that you are concerned about or feel is important about your child's health:_____
_____
_____.

Parent's Signature_____Reviewed by MD_____
(Initials)