Division of Neuroscience

PHOENIX CHILDREN'S *Medical Group*

PATIENT HISTORY

Name: _____
MR #: _____
DOB: _____
or Apply Patient Label

Please complete the following:

Patient's Name: _____

Age of Child: _____ **Date of Birth:** _____ **Primary Language:** ☐ English ☐ Español ☐ Other _____

Is your child: ☐ Right handed ☐ Left handed ☐ Both

	Name	Address	Telephone	Fax
Primary Care Physician				
Referring Physician				

Other Providers Caring for your child:

Specialty	Name	Address	Telephone	Fax

What are your main questions or concerns that brought you to our office:

1. _____
2. _____
3. _____

List current prescription, over the counter, and herbal medications, vitamins, and supplements (include dose and schedule):

Medication	Dose	How Often

List allergies and drug reactions:

_____

_____

_____

Are immunizations up to date? ☐ Yes ☐ No

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List past medical problems:

List past surgeries (include dates or age at time of surgery and place of surgery if possible):

List previous medications used to treat the condition you are coming in for today:

List previous diagnostic tests or labs you have had, where they were done and when:

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Pregnancy, Labor, and Delivery

Prenatal screening completed (circle results):

Group B Strep	Positive	Negative	Don't Know	Not Done
Hepatitis B	Positive	Negative	Don't Know	Not Done
HIV	Positive	Negative	Don't Know	Not Done
Rubella	Positive	Negative	Don't Know	Not Done

Information about Birth Mother (please answer):

Age at delivery?		
What number pregnancy was this		
What number live birth for mother?		
How many pounds were gained during this pregnancy?		
Was conception by invetro fertilization?		
Was genetic testing done?		
How many prior miscarriages?		
How many prior abortions?		

During the pregnancy, did the birth mother have any of the following concerns? (circle response)

Anemia	Bleeding	Fever	Infection	Multiple fetus
Preterm labor	High blood pressure	Exposure to X-rays	Gestational Diabetes	

During pregnancy, did the birth mother use (please list):

Medications	
Cigarettes	
Alcohol	
Street Drugs	

Child birth:

Hospital of birth		Length of labor			
Gestational age?		Presentation	☐Head	☐Breech	☐Arm
Birth weight		Difficult delivery?	☐ Yes	☐ No	
Birth length		Vacuum / forceps	☐ Yes	☐ No	
Head size		Arm or shoulder stuck	☐ Yes	☐ No	
☐ Vaginal	☐ C-section				
If C-section, why?					

After delivery, did the child experience any of the following? (Please circle)

Resuscitation	ICU care	Bleeding in Brain	Infection
Ventilator	Jaundice	Hydrocephalus	Eye problems
Oxygen	Feeding problems	Seizures	Hearing problems
CPAP	Apnea / Bradycardia	Blood transfusion	Birth defects
Arm/limb weakness			

Did the child require x-rays? _____

How old was child when discharged from the hospital? _____

To whom was child discharged? _____

Did the Birth Mother have post-partum depression (feel sad after delivery)? ☐ Yes ☐ No

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Developmental History

Do you think your child developed normally? ☐ Yes ☐ No
Do you think your child can see well? ☐ Yes ☐ No Formally tested? ☐ Yes ☐ No
Do you think your child can hear well? ☐ Yes ☐ No Formally tested? ☐ Yes ☐ No

At what age did your child meet these milestones? Indicate age in months.

MOTOR		SELF-HELP		LANGUAGE	
Sit up		Hold bottle		Babble	
Crawl		Give up bottle		Mama / Dada	
Walk alone		Use Spoon		Another word	
Run		Use Fork		Understand "no"	
Pedal trike		Drink from open cup		Point	
Bicycle		Undress		Wave	
Stairs		Toilet-trained		Follow command	
Pincer grasp		Dry at night		2-word phrases	
Prefer one hand		Dress self		3-word phrases	

Does your child require or have special equipment of daily living?

☐ Braces _____
☐ Walker or crutches _____
☐ Wheelchair _____
☐ Communication devices _____
☐ Other _____

THERAPY HISTORY

Did your child receive early intervention? ☐ Yes ☐ No
If yes, please describe:

	From Whom?	How often?
Speech		
Occupational Therapy		
Physical Therapy		

SCHOOL HISTORY

SCHOOLS & PRESCHOOLS ATTENDED	DATES ENROLLED	SPECIAL EDUCATION	THERAPIES

Performance in School Excellent Good Average Poor
Reading level- if known: Excellent Good Average Poor
Math level- if known: Excellent Good Average Poor

Behavior- Does your child have any of the following:	At home?	At school?
Hyperactivity	☐	☐
Short attention span	☐	☐
Impulsivity	☐	☐
Poor judgment	☐	☐
Moodiness	☐	☐
Distractibility	☐	☐

Has your child had developmental or neuropsychological testing? ☐ Yes (please explain) ☐ No
Where? _____

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Results: _____

Family History

☐ No known family health problems ☐ Unknown, patient is adopted

Do parents, siblings, grandparents, aunts, uncles, or cousins have any of the following? If so, who?

	Condition	Which family member?
☐	Asthma	
☐	Bleeding / Clotting disorder	
☐	Diabetes	
☐	Heart Disease	
☐	Hypertension	
☐	Early or sudden death	
☐	Liver Disease	
☐	Cancer	
☐	Thyroid	
☐	Neurofibromatosis	
☐	Tuberous Sclerosis	
☐	Genetic / Metabolic Disorder	
☐	Brain or spinal tumor	
☐	Craniosynostosis	
☐	Headaches / Migraines	
☐	Seizures/Epilepsy	
☐	Nerve or Muscle disease	
☐	Birth defects	
☐	Blind / Deaf	
☐	Cerebral Palsy	
☐	Spina Bifida	
☐	Down Syndrome	
☐	Movement Disorders	
☐	Tics / Tourette syndrome	
☐	Intellectual Delay	
☐	Developmental Delays	
☐	Learning Disabilities	
☐	ADHD / attention problems	
☐	Hyperactivity	
☐	Drug abuse	
☐	Alcoholism	

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☐	Bipolar Disorder	
☐	Depression	
☐	Anxiety / OCD	
☐	Fears / Phobias	
☐	Sleep Disorder	

Social History

Who does the child live with? _____

Are parents together? ☐ Yes ☐ No ☐ Separated ☐ Divorced ☐ Never married

Who is the custodial parent? _____

Mother's occupation / Employer: _____

Father's occupation / Employer: _____

Does the child go to day care? ☐ Yes ☐ No

Who else cares for the child? _____

Siblings and ages: _____

What pets do you have? _____

Does the patient play any sports or have any hobbies? _____

Any recent changes that have taken place that may impact the child's life? _____

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General Review of Systems

Does the patient have any of the following problems or complaints? Please check.

Yes	No	General
☐	☐	Recent fevers, chills, or sweats
☐	☐	Significant weight loss or weight gain
☐	☐	Change in behavior
☐	☐	Tiredness or drowsiness
☐	☐	Lack of interest in play
☐	☐	Loss of appetite
☐	☐	Problems related to sleep

Yes	No	Skin
☐	☐	Rashes or sores
☐	☐	Birth marks
☐	☐	Other problems:

Yes	No	Endocrine
☐	☐	Excessive sweating
☐	☐	Excessive thirst and urination
☐	☐	Excessive hunger
☐	☐	Always too cold or too hot
☐	☐	Premature sexual development/ early onset puberty
☐	☐	Thyroid problems
☐	☐	Other problems:

Yes	No	Eyes
☐	☐	Decreased vision or blurred vision
☐	☐	Double vision
☐	☐	Lazy eye or eyes not working together
☐	☐	Wears glasses or contacts
☐	☐	Other problems:

Yes	No	Ears, Nose, Throat
☐	☐	Hearing loss
☐	☐	Ringing in ears
☐	☐	Ear infections or drainage from ears
☐	☐	Nasal discharge or congestion
☐	☐	Difficulty swallowing liquids or solids
☐	☐	Drooling

Yes	No	Gastrointestinal
☐	☐	Nausea and / or vomiting
☐	☐	Tummy pain or discomfort
☐	☐	Feeding problems
☐	☐	Gastro-esophageal reflux
☐	☐	Constipation or diarrhea control
☐	☐	Loss or change in bowel control
☐	☐	Other problems

Yes	No	Urinary
☐	☐	Frequent or excessive urination
☐	☐	Pain on urination
☐	☐	Blood in urine
☐	☐	Urinary tract infections
☐	☐	Loss or change in bladder control
☐	☐	Bedwetting
☐	☐	Other problems:

Yes	No	Muscles and Bones
☐	☐	Joint pain or joint swelling
☐	☐	Muscle spasms or cramps
☐	☐	Weakness, excessive falling
☐	☐	Excessive tightness of muscles
☐	☐	Spasticity
☐	☐	Abnormal postures
☐	☐	Uncontrollable movements
☐	☐	Tremors or tics
☐	☐	Scoliosis / curvature of spine
☐	☐	Broken bones
☐	☐	Other problems:

Yes	No	Hematological
☐	☐	Frequent or easy bruising
☐	☐	Trouble controlling bleeding
☐	☐	Anemia
☐	☐	Other problems:

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Yes	No		Yes	No	
☐	☐	Regurgitation through the nose			**Dental**
☐	☐	Frequent or worsening gagging	☐	☐	Cavities
☐	☐	Change in quality or pitch of voice	☐	☐	Problems brushing teeth
☐	☐	Snoring	☐	☐	Has not seen dentist
☐	☐	Other problems:			**Sleep Problems**
		Cardio-Respiratory	☐	☐	Sleeplessness
☐	☐	Breathing problems	☐	☐	Teeth grinding
☐	☐	Wheezing	☐	☐	Excessive daytime sleepiness
☐	☐	Coughing	☐	☐	Sleepwalking
☐	☐	Apnea (breathing stops)	☐	☐	Nightmares
☐	☐	Blueness around the mouth			**Psychiatric**
☐	☐	Heart murmur	☐	☐	Severe mood swings ☐ Depression
☐	☐	Chest pain	☐	☐	Severe behavior ☐ Other

Review of Neurological System

Yes	No		
☐	☐	Dizziness with exercise	_____
☐	☐	Neck or back pain	_____
☐	☐	Numbness or tingling	_____
☐	☐	Dizziness or light-headedness	_____
☐	☐	Fainting	_____
☐	☐	Seizures	_____
☐	☐	Staring spells	_____
☐	☐	Tremors	_____
☐	☐	Problems with balance	_____
☐	☐	Change in strength or coordination	_____
☐	☐	Change in gait or walk	_____
☐	☐	Confusion or disorientation	_____
☐	☐	Change in behavior	_____
☐	☐	Change in school performance	_____
☐	☐	Problems with concentration	_____
☐	☐	Problems with memory	_____
☐	☐	Problems with understanding speech	_____
☐	☐	Prior head injury with or without loss of consciousness	_____
☐	☐	Prior neck injury	_____
☐	☐	Problems with continence, Urinary or Fecal or Both:	_____
☐	☐	Prior trauma or abuse	_____
☐	☐	Headaches	_____

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Form completed by
Signature & Printed Name: _____ Date & Time: _____

Relationship to patient: _____

Reviewed by: _____ Date/Time: _____

Printed Name: _____