NEUROLOGY INITIAL INTAKE FORM

Date:

Child's last name	**First Name**	**M.I.**	**Date of Birth**

1.	2.	3.
Best daytime phone numbers.	**Emergency cell number**	

Primary Care Physician	**Other specialists to receive records**	

Why are you here today? What do you want to have done today?
Chief complaint:

Child lives with: ☐Biological Mother / Father ☐Adopted Mother / Father ☐Foster Parents ☐Other
Number of Siblings: Ages:

Medications		**Allergies**
		Drug
		Food
		Environmental

Current Medical problems and diagnosis

Hospitalizations: Reason	Number of Days	Age

Surgeries / Injuries:	Surgeon	Outcome	Age
Problems with anesthesia?			

Diagnostic tests	When	Where	Results on chart?
EEG			
MRI			
CT			
Blood work			
Other			

Maternal Hx		Childs birth HX		Developmental Hx	
Prenatal Care		Full term/premature		Sit alone	Age
Alcohol use		Length of hosp stay		1st words	Age
Smoking		NICU stay?		Walked	Age
Infections		Vag / c-sect		School grade	
Exposure to drugs		Apgars		School performance	
Preg duration		Birth wt / length		Physical therapy	
Complications		Tone (stiff-floppy)		Occupational therapy	
		Suck/ eat well		Speech therapy	
		Oxygen or vent			
		CPR			
Family Hx	**Who**			**Who**	
H/A Migraines			SIDS		
Dev delay			MS		
Behavioral			Seizures		
Cancer			Stroke		
Learning Dis			Autism		

Systems Review

Neurologic	Yes	No	ENT	Yes	No	Respiratory	Yes	No
Tics			Hearing loss			Chronic Cough		
HA / migraines			Earaches/drainage			Phlegm		
Dev Delay			Sinus problems			Asthma/wheezing		
CP			Allergic Rhinitis			SOB		
Weakness			Nose Bleeds			Hoarseness		
Stroke			Mouth sores			Spitting up blood		
Sleep patterns			Sore throat			Tracheotomy		
Coordination/balance			Bad taste in mouth					
Sudden visual loss			Swollen gland in neck			**Cardiac**		
Incontinence						Murmur		
Head injury/concussion			**Endocrine**			High blood pressure		
Hydrocephalus			Diabetes			Chest pain		
Shunt revisions			Thyroid			Irregular heartbeat		
Tremor/shaking						Swelling		
			Eyes / Vision					
			Glasses/contacts			**Psychosocial**		
			Cataract			ADD / ADHD		
			Blindness			Anxiety		
			Blurred or double vision			Depression/suicidal thoughts		
Seizures			Lazy eye/ strabismus			Bipolar		
Drops held item			**Musculoskeletal**			Learning Disability		
Eye movement			Weakness			Biting self/others		
Falls down			Muscle pain			Aggression/ rage attacks		
Respond to name			Joint pain or swelling					
Responds to touch			Back or neck pain			**HEM/lymph**		
Staring			Difficulty walking			Bleeding		
Zoning out						Enlarged glands		
			GI					
			Poor Appetite					
			No weight gain			**Skin**		
			Weight loss			Eczema / rash		
			Unusual fatigue			Bruises		
			Lack of energy			birthmarks		
			Constipation					
			Diarrhea					
			Jaundice					
			Nausea/vomiting					