Child Neurology Consultants of Austin

New Patient Intake Form

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Relationship to Patient: _____

Pediatrician/PCP Name: _____ Pediatrician Phone: _____

Additional Doctors/Nurse Practitioners: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Chief Complaint/Reason for the Visit:

Current Medications (please ask for a printed list from our system to correct):

Medication	Dosage (# cap/tab/mg/mL)	How often?

Allergies (please list any to medications or other):

Review of Systems (please circle any symptoms that your child has today for the visit):

1. *General*: weight loss weight gain appetite loss appetite increase fever decreased energy

2. *Cardiovascular*: palpitations leg swelling fast heart rate chest pain high/low blood pressure

3. *Respiratory*: wheezing shortness of breath cough

4. *Gastrointestinal*: nausea vomiting constipation diarrhea jaundice abdominal pain blood in stool

5. *Genitourinary*: blood in urine pain during urination need to urinate suddenly odor in urine cloudy urine increased urination decreased urination urine incontinence

6. *Musculoskeletal*: weakness joint pain joint swelling muscle pain stiff neck

7. *Skin*: rash dry skin excessive sweating itching skin lesions hair loss excessive body hair acne

8. *Neurological*: headache tingling numbness seizures difficulty with balance dizziness fainting trembling or shaking (tremor) snoring excessive sleepiness difficulty falling asleep blurred vision double vision ringing in the ears head injury slurred speech difficulty finding desired words memory lapses or loss abnormal movements

9. *Psychological*: behavior as expected for age depressed anxiety behavior issues mood swings irritability aggression poor school performance daydreaming

10. *Endocrine*: frequent urination excessive drinking of fluids heat/cold intolerance breast buds menstrual cycle irregularity heavy menstrual periods

11. *Hematologic*: bruising bleeding nosebleeds gums bleeding swollen glands

Past Medical History (please circle any past medical problems that your child has had):

Acid Reflux/GERD	Concussion	Hospitalizations	Osteoporosis
ADD/ADHD	Congenital Anomalies	Hyperlipidemia	Pneumonia
Anemia	Constipation	Hypertension	Psychiatric Illness
Aneurysm	Depression	Hyperthyroidism	Respiratory Problems
Anxiety Disorder	Developmental Delay	Illicit Drug/Alcohol Use	Scoliosis
Arthritis	Diabetes	Infectious Disease	Seizures
Asthma	Diarrhea	Kidney Disease	Shortness of Breath
Autism	Eczema	Liver Disease	Skin Condition
Autoimmune Disease	Encephalitis	Lupus	Sleep Disorder
Back Problems	Epilepsy	Meningitis	Speech Delay
Bedwetting	Fibromyalgia	Mental Problems	Stroke
Birth Defects	Genitourinary Disease	Migraines	Tuberculosis
Bleeding Disorder	Glaucoma	MRSA	Tuberous Sclerosis
Blood Disease	Head Trauma/Injury	Multiple Sclerosis	Ulcers
Brain Tumor	Headaches	Musculoskeletal Disease	Urinary Tract Infections
Cancer	Hearing Problems	Neck Injury	Vertigo
Cardiomyopathy	Heart Murmur	Neurological Disease	Vision Problems
Cerebral Palsy	Heart Problems	Neurological Problems	
Chicken Pox	Hernia	Organ Transplant	
Chronic Pain	Hives	Orthopedic Problems	

Surgical History (please list any past surgeries that your child has had):

Surgery	Date of Surgery	Reason/Notes

Family History (please list any family members with the following diagnoses ex: mom, dad, paternal aunt…):

ADHD:_____
Autism:_____
Autoimmune Disease:_____
Depression:_____
Developmental Delay:_____
Epilepsy:_____
Febrile Seizure:_____
Genetic/Hereditary Disease:_____
Headache:_____
Learning Disability:_____
Mental Health Problem:_____
Migraine:_____
Muscle Disease:_____
Seizure:_____
Other:_____
_____

Birth and Social History:

Birth Weight:_____ Was the child full term at birth? _____ If no, how many weeks? _____

Birth Complications?_____ Delivery type: Vaginal C-section Breech

Did the baby come home from the hospital with you? Yes No

If not, how long were they in the hospital?_____

Immunizations up to date? Yes No

Age when first rolled over: _____ Age when able to sit independently: _____

Age when started crawling: _____ Age when started walking: _____

Age when first words: _____ Age when started speaking in sentences: _____

Therapies: (indicate # of sessions/week):

OT _____ hours, _____ days/week
PT _____ hours, _____ days/week
ST _____ hours, _____ days/week
ABA _____ hours, _____ days/week
Aqua therapy _____ hours, _____ days/week
Hippo therapy _____ hours, _____ days/week
Behavioral _____ hours, _____ days/week
Other _____ hours, _____ days/week

Grade in school: _____ Education: regular special inclusion homeschooled

Please circle any school problems with: reading motivation behavior peer relationships

Parents' marital status: Married Never Married Separated Divorced Widowed

Parent Occupations: Father:_____ Mother: _____

Who lives at home with your child? (adults, children, pets…)

_____

Does anyone smoke around the child?_____

Additional Information and Questions?

Provider Signature of Review:_____ Date:_____