Charlotte Neurological Services, PLLC

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Dear Patients, Parents and Caregivers:

Welcome to Charlotte Neurological Services, we work together with you as a team to provide thorough, evidence-based neurological evaluations and develop individualized treatment plans for your child. We believe that this results in more accurate diagnoses and helps build supports necessary for your child's continued success.

Please arrive 5 **minutes** prior to your appointment time. We also ask that you fill out this packet in its entirety prior to your arrival for the evaluation. Please also **bring copies** of reports from previous neurologic or school evaluations as well as any results of prior testing including imaging, laboratory tests, school evaluations, etc. that you would like to review and discuss.

I look forward to seeing you soon and starting on this journey together.

Sincerely,

Liya Beyderman, MD

Liya Beyderman, MD, FAAP
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PLEASE COMPLETE ALL FORMS PRIOR TO YOUR APPOINTMENT

Charlotte Neurological Services, PLLC

Patient Name:	**Patient DOB:**

In order to help us get to know you and your child better, please answer the following questions and **PLEASE bring this FORM to your appointment.**

1. Is English the primary language in your home? [ ] Yes [ ] No
2. Please provide the name and address of **your referring physician**:

   Name: ______________________________

   Address: ______________________________

   A copy of this report will be mailed to your PCP unless we are asked otherwise.

3. Is this your child's first neurological evaluation? [ ] Yes [ ] No

   If no, then please list names and facilities below and number of professionals seen previously for this problem:

   ____

4. Please list the **concerns** you have about your child?

5. When did you first become concerned about your child?

6. Please list your goals for this evaluation:
   a.
   b.
   c.

BIRTH HISTORY

Name of person completing this form: ______________________________

1. Are you the [ ] Parent or [ ] Guardian?
2. **If the child is adopted let us know if this can be discussed: [ ] Yes [ ] No**
3. Mother's age at time of child's birth: Father's age at time of child's birth:
4. Did the mother have regular prenatal care? [ ] Yes [ ] No

5. Were there any medical problems during pregnancy? If yes, circle all that apply below:

Preeclampsia	High Blood Pressure	Surgery	Anemia	Poor Diet	Vomiting
Bleeding	Illness/Infection	Diabetes	Fever	Psychiatric (depression)	
Eclampsia	Accidents	Poor or excessive weight gain			

6. Did the mother use any medications including prescriptions, over the counter, recreational drugs, alcohol, or herbal remedies? Please circle and explain if any.

____

7. Pregnancy history:

# of Pregnancies= # of Live births= #Miscarriages= # of Terminations=

8. Was the baby born by C-section or vaginally, please circle one.

Premature (<36 weeks) On time (37-42 weeks) Post-term (>42 weeks)

9. What the baby's birth weight? ______________________________
10. What were the baby's Apgar Scores? ______________________________
11. Were there any problems with delivery? If yes please describe below.

____

12. How old was the infant when he/she went home from the nursery?

13. Did the infant have to go home on any medications or with any equipment?

____

CHILD DEVELOPMENT

1. Was your child's development slower than his/her peers or siblings? [ ] Yes [ ] No
2. Has your child ever lost previously acquired skills? [ ] Yes [ ] No
3. Is your child toilet trained? [ ] Yes [ ] No At what age did he/she toilet train?
4. Are there accidents during night or day? [ ] Yes [ ] No
5. Would you describe your child as clumsy or well coordinated, *please circle*.
6. Was or is your child ever a toe walker? [ ] Yes [ ] No
7. Is your child overly flexible? [ ] Yes [ ] No
8. Are there any sensory concerns with textures, sounds, etc.? [ ] Yes [ ] No
9. Can your child do things with his/her body other kids can't? (Ex. Double jointed) [ ] Yes [ ] No
10. Do you have any other developmental concerns?
11. If your child is less than 6 years of age, please fill out the following: *At what age did your child?*

GROSS MOTOR	**FINE MOTOR**
Had Head Control -	Held objects-
Rolled over -	Used spoon-
Sat independently -	Dressed self-
Walked -	Handedness (circle left or right)
Threw a ball-	Ride a bike-
LANGUAGE and Cognitive Development	
Babbled-	Pointed to a picture-
Responded to verbal stimuli-	Began pretend play-
Tracked objects-	Identified body parts-
Smiled/Laughed-	Wrote first and last name-
Said single words-	Counted to 5-
Combined words into sentences-	Read-

PAST MEDICAL HISTORY

1. Does your child currently have any neurological/medical/psychiatric diagnosis?
    a.
    b.
    c.
    d.
    e.
    f.

2. Has your child ever had any surgeries? [ ] Yes [ ] No
If yes, then what kind?

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3. Has your child ever been hospitalized for any reason? [ ] Yes [ ] No
If so please list for what and when below.

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4. Has your child had prolonged (>few hrs) fevers greater than 104F or been suffering from recurrent illnesses? (Fever, colds, ear infections, etc)? [ ] Yes [ ] No

5. Does your child suffer from allergies? [ ] Yes [ ] No
If yes, please circle (food, seasonal, or medication and list below:

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6. Has your child ever had a seizure or a convulsion? [ ] Yes [ ] No
7. Are there episodes of poor responsiveness, staring, "spacing " or eye fluttering? [ ] Yes [ ] No
8. Does your child have involuntary movements ie tics, sniffing, throat clearing? [ ] Yes [ ] No
9. Has your child had his hearing tested in the past? [ ] Yes [ ] No
10. Has your child been seen by an Optometrist or an Ophthalmologist in the past? [ ] Yes [ ] No
11. Does your child get frequent sinus or ear infections? [ ] Yes [ ] No
12. Has your child ever had meningitis or encephalitis? [ ] Yes [ ] No
13. Does your child have a history of passing out, irregular heartbeat, or syncope? [ ] Yes [ ] No
If yes, then please explain:

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14. Has your child ever had a major head injury/concussion? [ ] Yes [ ] No
If yes, please fill out chart below:

	Event #1	Event #2	Event #3
Age at Injury			
Date of injury			
Cause of Injury			
Unconscious/passed out?			
Treatment/Evaluation			

MEDICATION and PRIOR TESTING HISTORY

Are your child's **immunizations** up to date? [ ] Yes [ ] No *If not, please explain and comment on any reactions:*

List any prior testing including (EEG, MRI, blood work, genetic testing, CT, neuropsychological etc.)

Date	Test	Result

Current Medications

Name of Medication	Start	Dose	Reason for Medication	Side effects
a.				
b.				
c.				
d.				

Past Medications

Name of Medication	Start	Dose	Reason for Medication	Side effects
a.				
b.				
c.				
d.				

Does your child have any problems with his/her **sleep**? [ ] Yes [ ] No

Bedtime	Time falls asleep	Wakes up at

Please circle any that apply about your child's sleep:

Restless sleeper	Experiences Nightmares	Requires Co-sleeping	Bedwetting
Awakens during night	Snoring	Sleeps very few hours	Sleep walking
Night terrors	Difficult to awaken		

Has your child ever had a sleep study? [ ] Yes [ ] No

EDUCATIONAL HISTORY

Please bring a copy of IEP or 504 Plan for us to review if you have it.

1. Is your child currently receiving services from Early Intervention? [ ] Yes [ ] No
2. Is your child currently enrolled in a school program? [ ] Yes [ ] No
3. What is the name of your child's school?
4. Has your child been evaluated by the Child Study Team or Intermediate Unit? [ ] Yes [ ] No
5. Is your child classified? [ ] Yes [ ] No If yes what is the classification?
6. Is your child receiving services from the school? [ ] Yes [ ] No *If yes please circle:*
   PT ST OT Lunch Bunch Counseling Other:
7. What are areas that your child excels in?
8. What are areas of difficulty?
9. What are your child's average grades in school?
10. Does your child miss days from school often? [ ] Yes [ ] No
11. Has your child had behavioral problems in school &/or been suspended, etc? [ ] Yes [ ] No

PSYCHIATRIC HISTORY

1. Do you have any psychiatric concerns about your child such as anxiety, moodiness, sadness, etc?
   [ ] Yes [ ] No **If NO, then move to the next section.**
2. Are there any prior psychiatric diagnoses? [ ] Yes [ ] No *Please list if yes, below.*
3. Has your child ever had in-patient psychiatric treatment /seen by mobile crisis? [ ] Yes [ ] No
4. Does your child have any history of suicidal ideation? [ ] Yes [ ] No
5. Does your child have a history of hallucinations? [ ] Yes [ ] No
6. Does your child your child ever had his urine tested for substances of abuse? [ ] Yes [ ] No
7. Has your child ever been arrested or placed on probation? [ ] Yes [ ] No
8. Any history or exposure to domestic violence, sexual abuse, physical abuse or neglect?
   [ ] Yes [ ] No If yes, p*lease circle any that apply above.*

Please circle any of the symptoms below that could apply to your child.

Explosive Anger	Oppositional Behaviors	Excessive talking	Nightmares
Mood variations	Irritability	Sadness	Decreased sleep
Self-injurious	Anxious	Closed off	Overly excitable

BEHAVIORAL/CONDUCT HISTORY

1. Do you have concerns about your child's behavior? [ ] Yes [ ] No
2. What specific behaviors are you most concerned about?

 ____
3. How do you discipline your child? (ex. chores, going to room, time-out)

 ____
4. Is your child?
    a. Inattentive (can't focus, careless, disorganized, distractible) [ ] Yes [ ] No
    b. Impulsive (acts without thinking, interrupts) [ ] Yes [ ] No
    c. Hyperactive (can't stop moving, fidgety) [ ] Yes [ ] No
5. Have you ever seen a behavior specialist? [ ] Yes [ ] No
6. What activities does your child enjoy for fun?

 ____
7. How much time is spent on TV, video games and computer?

Please fill out the chart below:

Poor social skills ("personal space issues", social cues, isolated)	[ ] Yes [ ] No
Please explain -	
Trouble with transitions? (Changing activities, routines, leaving places)	[ ] Yes [ ] No
Please explain -	
Problems interacting with other kids?	[ ] Yes [ ] No
Please explain -	
Narrow Interests? (facts, cars, collections, etc)	[ ] Yes [ ] No
Please explain -	
Literal/Formal language (humor/abstract concepts are hard)	[ ] Yes [ ] No
Please explain -	
Odd voice quality (volume, pitch, cartoonish, tone)	[ ] Yes [ ] No
Please explain -	
Empathy (understands emotions of others)	[ ] Yes [ ] No
Please explain -	
Joint Attention (looks for approval/attention when doing something)	[ ] Yes [ ] No
Please explain -	
Repetitive/ Self-stimulatory (spin, head bang, twirling, hand flapping)	[ ] Yes [ ] No
Please explain -	
Ritualistic/Obsessive (loves routine, lines up, picking, nail biting)	[ ] Yes [ ] No
Please explain -	
Aggressive (biting, breaking things, hitting, etc)	[ ] Yes [ ] No
Please explain -	
Self-injurious (head banging, biting self, pulling hair, etc)	[ ] Yes [ ] No
Please explain -	
Dangerous (running away, jumping off heights, etc)	[ ] Yes [ ] No
Please explain -	

DIETARY HISTORY

1. Is your child on any special diet? [ ] Yes [ ] No

   If yes, please circle all that apply below:

   Gluten-free Casein-free Low-carb Feingold Modified Atkins Other: ______

2. Does your child have any food allergies? [ ] Yes [ ] No *If yes please describe below:*

   ______

3. Does your child have problems with eating or unusual food choices? [ ] Yes [ ] No

4. Does your child use or has ever used/taken any of the following, please circle any that apply:

B12 injections	B12 supplements	Amino Acid Supplements
Chelation	Fatty Acid supplements	Plasmapheresis
IVIG	Herbal supplements	Vitamins (multi vitamins, etc)
Hyperbaric Oxygen therapy	Probiotics	Carnitine/Carnitor
Supplements mineral or herbal (zinc, valerian, gingko, iron..)		Folinic Acid

5. Does your child eat well-balanced meals? [ ] Yes [ ] No
6. What are you child's favorite foods?

   ______

7. Do you have concerns about your child's weight? [ ] Yes [ ] No

8. Does your child have any unusual food preferences? [ ] Yes [ ] No

9. Any problems with eating, chewing , or swallowing food and/or liquids? [ ] Yes [ ] No

   ______

10. Has your child ever been to a feeding clinic or a feeding program? [ ] Yes [ ] No

SOCIAL and FAMILY HISTORY

1. ***Please circle who the child currently lives with:***

Mother	Stepmother	Adoptive mother/father	Foster Mother/Father
Father	Stepfather	Grandmother/Grandfather	Other:

2. Father's Occupation: Mother's Occupation:

3. Are the parents married, unmarried, divorced, separated, widowed? ***Please circle.***
4. Any **siblings** living in or out of the home? [ ] Yes [ ] No *If yes, please list them, their age, and any neurological, psychological or learning problems if any:*

5. Who else lives in the home? *Please list siblings, aunts, uncles, etc and their ages:*

6. **Anyone in the child's biological family have any of the following?**

	None	Mo	Fa	Sis	Bro	Mat GM	Mat GF	Pat GM	Pat GF	Mat Aunt	Pat Aunt	Mat Unc	Pat Unc	Other
Attention deficit disorder														
Autism/PDD/Asperger's														
Behavior problems														
Birth defects/Brain Injury														
Cerebral palsy														
Infant/child death														
Chromosome abnormality (genetic d/o, ex. Down's)														
Brain tumor														
Congenital Hearinq Loss														
Developmental Delay														
Epilepsy														
Febrile seizures														
Headache														
Leaminq disability														
Mental illness/psychiatric d/o ex. (OCD, Anxiety, Depression)														
Mental retardation														
Metabolic abnormality														
Migraines														
Neurofibromatosis														
Stroke														
Syncope														
Tic Disorder														
Tourette's Syndrome														
Tuberous Sclerosis														
Other, please list														

REVIEW OF SYSTEMS

Please circle any problems your child is experiencing at this time:

Appetite change Weight loss Weight gain Unexplained fevers Difficulty tolerating heat or cold	CONSTITUTIONAL
Birth marks Rash	DERMATOLOGIC
Difficulty seeing Difficulty hearing Eyeglasses Contacts Ear or Sinus infections Nasal congestion or drainage Swallowing problems Hearing aids	EYES, EAR NOSE and THROAT
Sensation that heart is racing Chest pain	CARDIOVASCULAR
Shortness of breath Asthma	RESPIRATORY
Problems eating Nausea or vomiting Abdominal pain Changes in bowel control Diarrhea or constipation	GASTROINSTESTINAL
Changes in bladder control Menstrual period problems Bedwetting	GENITOURINARY
Broken bones (now or ever) Neck, back or joint pain Changes in strength or coordination Weakness	MUSCULOSKELETAL
Easy bleeding or bruising Allergies Enlarged lymph nodes	HEMATOLOGIC/IMMUNOLOGIC/ENDOCRINE
Changes in school performance Tremors Fainting Frequent headaches Dizziness Daydreaming or staring spells	NEUROLOGIC
Depression Anger Anxiety Obsessions or compulsions Irritability Mood swings	PSYCHIATRIC

Anything else you would like to share?

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