Neurological Questionnaire- (Child)

Patient Name _____ **SS#** _____
Parent/Guardian Name (If a minor) _____ **Relationship** _____
Address _____ **City/State/Zip** _____
Home Phone _____ **Cell Phone** _____ **Date of Birth** _____
Sex M F **Age** _____ **Email Address** _____
How did you hear about our clinic? _____
Primary health challenge: _____ **Severity** 0-10 _____
Secondary challenge (if any) _____ **Severity** 0-10 _____
Medications: _____
Supplements: _____

Please rate the following 0-10 (0 = not at all 10 = worst you can imagine)

____Anxiety
____Depression
____ADD / ADHD
____Fatigue
____Mood Swings
____Anger

____Learning Disorder
____Unable to Focus
____Memory Problems
____Headaches
____Ringing in Ears

____Poor Concentration
____Obsessive Behavior
____Insomnia (getting to sleep)

____Insomnia (staying asleep)
____Difficulty using body parts

Do you have family members with any of the above difficulties? Yes____ N____If so, who?

Have you had a seizure at any time? Yes____ No____ If so, when?_____

Are your eyes sensitive to light? Yes____ No____

Have you had any head injuries (diagnosed or undiagnosed?) Yes____ No____

If yes, please explain_____

How many Auto Accidents have you been in? (fender benders count)_____

Please list any other accidents or falls_____

Please list any surgeries_____

What specific behaviors do you hope to see improve or be eliminated? _____

_____

1. Is there a family history of (if so, who)?
   a. Any psychiatric conditions? _____
   b. Any autism spectrum conditions? _____
   c. Any diagnosed autoimmune conditions? _____
   d. Any known genetic conditions? _____

2. How was Mom's pre pregnant health? _____
   a. Miscarriages? _____
   b. Fertility Treatments? _____
   c. Health of other children? _____
   d. Physical Abuse? _____
   e. Major Illnesses? _____
   f. Known Autoimmune Conditions (Rheumatoid Arthritis, Lupus, MS, Hashimoto's)? _____
   g. Toxin Exposure to:

Molds	____Yes	____No
Pesticides	____Yes	____No
Dental Work	____Yes	____No

   h. Known Infections _____Yeast _____Bacterial _____Parasite

i. Did Mom (while pregnant)
Drink alcohol ____Yes ____No
Drink coffee ___Yes ____No
Smoke tobacco ____Yes ____No
Take Progesterone ____Yes ____No
Take prenatal vitamins ____Yes ____No
Take antibiotics ____Yes ____No
Take other drugs ____Yes ____No
Excessive vomiting, nausea (more than 3 weeks) ____Yes ____No
Have a viral infection ____Yes ____No
Have bleeding ____Yes ____No
Group B strep infection____Yes ____No

3. Birth
   a. During the child's delivery, were forceps or suction used? _____
   b. Was birth by C-Section? _____
   c. Was labor induced? _____
   d. Did Mother have an epidural? _____
   e. What was child's APGAR score? _____
4. Infancy
   a. Was child exposed to mold? _____
   b. Was house treated with pesticides? _____
   c. Was the house painted, either inside or outside? _____
5. Motor Development
   At what age did your child do the following?
   Sit up _____ Crawl _____ Pull to Stand _____ Walk Alone _____
   Potty-trained _____ Dry at Night _____ First Words ("mama", "dada" etc.) _____
   Speak clearly _____ Lost language (if applicable) _____
   Lost eye contact (if applicable) _____
   Did your child display any "cute" behaviors when learning to crawl or walk? (for example, dragging on leg, or crawling on all fours with rear end up in air) _____
   Was child breast-fed? _____ How long? _____
   Bottle-fed? _____ Was formula Soy-based_____ Casein (Milk)-based? _____
   Did baby have any reactions to the formula? If so, describe _____
   At what age was cow's milk introduced? _____
   At what age was rice introduced? _____Wheat and other grains introduced at what age? _____

6. Early Childhood
   a. Number of earaches in the first two years _____
   b. Number of other infections in the first two years _____
   c. Number of times you had antibiotics in the first two years of life _____
   d. Number of courses of prophylactic antibiotics in the first two years of life _____
   e. First antibiotic at?
   f. First illness at? _____
   g. Has your child been vaccinated? _____
      If so, did they have any of the following after the vaccines? Diarrhea____ Crying_____
      Swelling at injection site? ____ Seizure____ Fever____ Irritable _____

7. Current Diet
   a. Does your child refuse to eat particular textures, temperatures, or certain kinds of food? (If so, describe) _____
   b. Does your child eat a lot of or crave any of the following?
      Sweets (cookies, candy, sugar)_____

Dairy products (milk, cheese, ice cream) _____
Breads, pasta, potatoes, chips _____
Sweet drinks (Gatorade, Powerade, Capri Sun, Sunny-D, Soda, Fruit juices) _____
Salty Foods _____

c. Does your child eat only 2-4 kinds of foods daily? _____

8. Gastrointestinal Issues
   a. Does your child suffer from any of the following?
      Constipation _____
      Diarrhea _____
      Bloating _____
      Dark circle under eyes _____
      Do the child's symptoms/behaviors get worse in the following weather?
      Damp_____ hot _____ misty_____ moldy_____musty_____
      Does the child wake at night laughing or giggling _____
      Child puts pressure on stomach (with hands or by laying over couch arms etc) _____

Please check which of the following applies to your child

__Miss the gist of a story or last to get a joke
__Tend to write very small
__Very good at finding mistakes
__Difficulty remaining seated when expected
__Difficulty remembering where things are
__Good memory for directions
__Difficulty understanding body language
__Act compulsively
__Difficulty with word problems
__Difficulty following through or finishing things
__Good reading comprehension
__Hyperactive-move excessively
__Blurts out thoughts and answers to questions
__Able to predict what others will do
__Fearful and anxious
__Trouble sustaining attention in routine situations
__Understand the "big picture" of words/phrases
__Appropriate social behavior and responses
__Able to focus
__Easily distracted by ordinary insignificant things

__Able to speak without sounding monotone
__Able to cry or be spontaneous
__Irregular heartbeat (fast or slow)
__Difficulty changing set behavior
__Tend to lose focus on visual tasks
__Start things, but don't finish
__Empathetic-sensitive to others feelings
__Lost in thought, unreachable, zoned-out
__Eye contact poor, not as expected
__Reacts well to <u>new</u> circumstances
__Speech sounds monotone
__Appropriate social behavior
__Adopts complicated rituals
__Collects particular things
__Corrects imperfections
__Draws only certain things
__Fixated on one topic
__Lines up objects precisely
__Lines things in neat rows
__Repeats old phrases, sentences
__Play is repetitive, very predictable
__Upset if things change
__Insists on what is wanted
__Likes looking at fans

__Likes flickering lights
__Tend to write very large
__Difficulty seeing patterns
__Draws accurate pictures
__Difficulty with geometry /algebra
__Unusually good memory
__Upset if things change
__Upset if things aren't "right"
__Silly inappropriate laughing/giggling
__Watches television for a **long** time
__Plays computer for a **long** time
__Difficulty modeling someone's behavior, but if told how to do something, can do it
__Difficulty reading
__Fatigue while reading
__Appears to be depressed
__Stumbles over words (gets worse with fatigue)
__Difficulty making decisions, judgments
__Uses one word for another
__Irregular hear rhythm (skipped beats, fluttering)
__Penmanship gets worse as continues to write
__Teeth grinding
__Tics
__Complains of muscle cramps
__Restless legs

__Tremors / Shakiness
__Bites of chews fingers
__Bites wrist or back of hands or arms
__Obsessive thoughts
__Gets stuck on a behavior
__Gets song stuck in head
__Panic attacks
__Poor handwriting
__Low motivation
__Excessive motivation
__Quick startle reflex
__Persistent phobias
__Easily embarrassed
__Easily sweats
__Hot or cold flashes/hot or cold hands
__Feelings of nervousness or anxiety
__Heart pounding, rapid heart rate, chest pain
__Trouble breathing or feelings of being smothered
__Avoidance of public places from fear of anxiety
__Periods of nausea and stomach upset
__Tendency to predict the worst
__Fear of being judged or scrutinized
__Excessive worrying about what others think
__Tendency to freeze in anxiety provoking situations
__Feelings of sadness
__Moodiness
__Negativity
__Low energy
__Irritability
__Suicidal Feelings
__Low self esteem
__Forgetfulness
__Face, lip movements or noises
__Feelings of hopelessness or powerlessness
__Feeling dissatisfied or bored
__Excessive guilt
__Crying easily
__Lowered interest in things considered fun
__Appetite changes

__Very sensitive to smells and odors
__Poor sense of smell
__Mild paranoia
__Memory problems
__Periods of forgetfulness
__Spaciness or confusion
__Periods of panic
__Frequent misinterpretation of comments as negative, when they are not
__Auditory or visual hallucinations
__**Sudden** fear, anger or sexual feelings
__History of family violence of explosiveness
__Short fuse or periods of extreme irritability
__Periods of rage without provocation
__Dark thoughts, thoughts of homicide or suicide
__Preoccupation with moral or religious ideas
__Reading comprehension problems
__Irritability that tends to build and then explode
__Ringing in ears
__Letters seen backwards
__Difficulty counting, calculating
__Child has difficulty understanding how he/she feels
__Without looking, have difficulty knowing "where" in space foot or hand is
__Report odd sensations (bugs crawling, tingling, burning, etc)
__Get claustrophobic, tunnel vision, or feeling that the world is closing in
__Have difficulty understanding how others feel
__Get surprised by things coming from the left side (more than from opposite side)
__Difficulty with spatial skills
__Difficulty with word problems in math
__Difficulty getting dressed

__Difficulty reading people's facial expressions
__Difficulty interpreting emotional content of a verbal conversation
__Confusion between left and right
__Speech is slurred
__Movement does not look coordinated
__Trips
__Falls or gets hurt when running or climbing
__Knocks things over when reaching
__Has trouble maintaining balance
__Drops things
__Fearful of harmless objects
__Fearful of unusual events
__Unaware of danger
__Unaware of self as a person
__Very sensitive to pain
__Climbs to high places
__Likes to be held upside down
__Likes to be swung in air
__Whirls self like a top
__Toe Walking
__Bothered by certain sounds
__Hearing loss
__Likes certain sounds
__Sensitive to loud noise
__Sounds seem painful
__Covers ears with sounds
__Likes to make loud noises with voice
__Bothered by bright lights
__Blinking
__Examines by smell sniffs things
__Licks things, puts things in mouth
__Examines things by sight
__Light is "calming"
__Fails to blink at bright light
__Daytime sleepiness
__Sleeps less than normally expected
__Sleeps more than normally expected