Neurology

* 1 5 1 8 1 3 *

LABEL OR PRINT

NAME

CH MRN

DOB GENDER M F

NEUROLOGY PATIENT QUESTIONNAIRE

To be completed by parent/guardian.

DATE: / /

What concerns do you have for today's visit?

____

____

____

Does the patient have any allergies? ☐ Yes ☐ No

Type of Reaction (ex. Rash, hives, difficulty breathing) ______________________________

If yes, which kind (can check more than one): ☐ Drug ☐ Food ☐ Environment

List allergies: ______________________________

Severity of Reaction ☐ Mild ☐ Moderate ☐ Severe

At what age did allergy first appear? ____________

Grade in school: ____________

Is your child receiving any special services?
(ex: Early Intervention, PT, OT, Special Ed)

____

Current performance in school:

____

☐ Please check the box if your child is 16 or older, and if you would like to speak with a social worker about guardianship/transition into adult care.

If you have filled out this form during the last year and the answers for the questions below have not changed please check the box and sign at the bottom of the page. ☐

Are the patient's immunizations up to date? ☐ Yes ☐ No

Missed immunization/reason: ______________________________

How do you (The parent/guardian) learn best? (Check all that apply)

☐	Observation	☐	Hands on	☐	Video
☐	Written materials	☐	One-on-one	☐	Other:
☐	Listening	☐	Group		

Is there anything you would like us to know about the religious, spiritual, cultural beliefs, traditions and practices of your family or extended family? ☐ Yes ☐ No

____

Do you have any questions or concerns about family support, health insurance or financial concerns related to your child's medical care? ☐ Yes ☐ No

____

Do you feel safe at home? ☐ Yes ☐ No

Is the patient the victim of any repeated teasing / taunting / harassment from peers? ☐ Yes ☐ No

______________________________ Parent/Guardian Signature

______________________________ Relationship to Patient

☐ ____________ CA/RN check and initial here to indicate that form has been reviewed with Parent/Guardian

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