Neurological Questionnaire- (Child)

Patient Name _____ **SS#**_____
Mother's Name_____ **Father's Name**_____
Are parents ____married ____separated/divorced _____deceased
Who lives in the home: ____Mom ____Dad ____Step parent ____Siblings ____Other
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

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

In order to serve you better, please check which of the following is most accurate:

1. This is the first place we have come seeking treatment for our child.
2. Our child is currently under care, but we are not satisfied with the results and looking to make a change.
3. We are just curious about brain mapping and want to see what the results look like.

In the space below, please give us a little background on your child. Things such as:

A brief summary of what treatments you have tried and how they have worked
Your major concerns
Treatment Goals
Anything important we should know