

# PEDIATRIC PATIENT HISTORY

Please complete your child's history questionnaire before your scheduled appointment. Present to our receptionist as you check-in.

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Age: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_ Handedness: R \_\_\_\_\_ L \_\_\_\_\_

Please describe the chief problem(s) that you are concerned about.

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Please place a check if the test has been done: State when and results below.

( ) Skull X-ray ( ) EEG ( ) CAT Scan ( ) MRI ( ) EMG ( ) Spinal Tap

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Has the patient ever been hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_  
Hospital/City Reason for Hospitalization

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List names of other professionals consulted. (Please ask these professionals to send us reports of their evaluations, if possible).

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Enter names and addresses of individuals to whom you would like a report of this consultation to be sent.

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

Medications that patient is taking: \_\_\_\_\_

Medications that patient has taken in past: \_\_\_\_\_

A. Name of School Patient Attends: \_\_\_\_\_ Grade \_\_\_\_\_  
Class type: Regular \_\_\_\_\_ Developmentally Handicapped \_\_\_\_\_ Multi-Handicapped \_\_\_\_\_  
Learning Disability \_\_\_\_\_ Behavior Disturbed \_\_\_\_\_ Gifted \_\_\_\_\_  
Tutored \_\_\_\_\_ Specify Subjects \_\_\_\_\_  
Has the child repeated any grades? Yes \_\_\_\_\_ No \_\_\_\_\_ Which grade? \_\_\_\_\_  
What is the child's school performance? Above average \_\_\_\_\_ Average \_\_\_\_\_ Below average \_\_\_\_\_  
Has there been a recent change in school performance? Yes \_\_\_\_\_ No \_\_\_\_\_  
Has your child been suspended? Yes \_\_\_ No \_\_\_ In School \_\_\_ Out of School \_\_\_; Expelled Yes \_\_\_ No \_\_\_

If your child is having problems in school, please ask the teacher to complete the enclosed questionnaire. If possible, bring with you or have the school send copies of any evaluations that have been done.

Please give details to questions answered "Yes".

Mother during Pregnancy

- B. Yes No Illnesses, bleeding or rashes? \_\_\_\_\_  
Yes No Medications other than vitamins? \_\_\_\_\_  
Yes No Smoke cigarettes? \_\_\_\_\_  
Yes No Drink alcohol? \_\_\_\_\_  
Yes No Take drugs? \_\_\_\_\_

Birth History

- Yes No Full Term?\_\_\_\_\_ Yes No Early?\_\_\_\_\_ Yes No Late?\_\_\_\_\_  
Yes No Breech presentation?\_\_\_\_\_ Yes No Cesarean section?\_\_\_\_\_ Elect Emergency  
Yes No Did the baby have any troubles during the first few days of life? \_\_\_\_\_

What was the baby's birth weight? \_\_\_\_\_  
How long did the baby stay in the hospital? \_\_\_\_\_  
Where was the baby born? \_\_\_\_\_

At what age was the baby able to:

- Roll over \_\_\_\_\_ Sit alone \_\_\_\_\_ Crawl \_\_\_\_\_  
Reach for objects \_\_\_\_\_ Walk alone \_\_\_\_\_ Climb stairs \_\_\_\_\_  
Say "MaMa-DaDa" \_\_\_\_\_ Single words \_\_\_\_\_ 3 word sentences \_\_\_\_\_  
Ride tricycle \_\_\_\_\_ Ride Bicycle \_\_\_\_\_ Tie Shoelaces \_\_\_\_\_  
Toilet trained: bladder \_\_\_\_\_ bowel \_\_\_\_\_

- Did child have speech problems? Yes No  
Has child received speech therapy? Yes No

- C. Has the patient had?  
Yes No Meningitis or Encephalitis \_\_\_\_\_  
Yes No Head Injury \_\_\_\_\_  
Yes No Other Serious Injury/Illness \_\_\_\_\_  
Yes No Hearing Problem \_\_\_\_\_  
Yes No Vision Problem \_\_\_\_\_  
Yes No Lung or Heart Problem \_\_\_\_\_  
Yes No Bowel or Bladder Problem \_\_\_\_\_  
Yes No An Operation \_\_\_\_\_  
Yes No Allergies \_\_\_\_\_  
Yes No Bad Reaction to Medication \_\_\_\_\_  
Yes No Seizures/Convulsions \_\_\_\_\_ If yes, please complete page 3  
Yes No Fainting \_\_\_\_\_ If yes, please complete page 4  
Yes No Abnormal Movements \_\_\_\_\_ If yes, please complete page 5  
Yes No Headaches \_\_\_\_\_ If yes, please complete page 6 and 7  
Yes No School and/or behavior problems \_\_\_\_\_ If yes, please complete page 8

Family History

| D.      | Age(Sex) | Education | Health |
|---------|----------|-----------|--------|
| Father  | _____    | _____     | _____  |
| Mother  | _____    | _____     | _____  |
| Sibling | _____    | _____     | _____  |

- Yes No Migraine Yes No ADHD  
Yes No Tension Headaches Yes No Dyslexia  
Yes No Seizures/Convulsions/Epilepsy Yes No Learning Problems  
Yes No Abnormal Movements Yes No Mental Retardation  
Yes No Tourettes Syndrome Yes No Behavior Problems  
Yes No Psychoses Yes No Drug Abuse  
Yes No Bipolar (Manic Depressive) Yes No Alzheimers  
Yes No Depression Yes No Heart Disease  
Yes No Obsessive Compulsive Disorder Yes No Diabetes

Are the parents? ( ) Married ( ) Divorced ( ) Separated ( ) Never Married ( ) Remarried

## SEIZURES

When did the seizures begin? Month/Year \_\_\_\_\_

How many different types of seizures are occurring? ( ) one ( ) two ( ) more

How long do the seizures last?

|                 | Type 1 | Type 2 |
|-----------------|--------|--------|
| seconds         | ( )    | ( )    |
| minutes         | ( )    | ( )    |
| an hour or more | ( )    | ( )    |

How often do the seizures occur?

|                       | Type 1 | Type 2 |
|-----------------------|--------|--------|
| at least once a day   | ( )    | ( )    |
| several times a week  | ( )    | ( )    |
| several times a month | ( )    | ( )    |
| several times a year  | ( )    | ( )    |
| less than once a year | ( )    | ( )    |

What happens during the seizures?

|                                    | Type 1 | Type 2 |
|------------------------------------|--------|--------|
| stares                             | ( )    | ( )    |
| flutters eyelids                   | ( )    | ( )    |
| turns blue                         | ( )    | ( )    |
| turns pale                         | ( )    | ( )    |
| loss of consciousness              | ( )    | ( )    |
| able to understand but not respond | ( )    | ( )    |
| falls to the ground                | ( )    | ( )    |
| bites tongue                       | ( )    | ( )    |
| eyes roll up                       | ( )    | ( )    |
| eyes turn to one side              | ( )    | ( )    |
| urine may be lost                  | ( )    | ( )    |
| jerking of arm(s) / leg(s)         | ( )    | ( )    |
| stiffness of arm(s) / leg(s)       | ( )    | ( )    |
| suddenly bends neck                | ( )    | ( )    |
| suddenly bends body                | ( )    | ( )    |
| smacks lips                        | ( )    | ( )    |
| picks at clothes                   | ( )    | ( )    |
| says words or sounds               | ( )    | ( )    |
| stops previous activities          | ( )    | ( )    |
| continues previous activities      | ( )    | ( )    |
| vomits                             | ( )    | ( )    |
| sleeps                             | ( )    | ( )    |

How do you feel when the seizure is over?

|              | Type 1 | Type 2 |
|--------------|--------|--------|
| normal       | ( )    | ( )    |
| headache     | ( )    | ( )    |
| nauseated    | ( )    | ( )    |
| muscles ache | ( )    | ( )    |
| sleepy       | ( )    | ( )    |
| confused     | ( )    | ( )    |
| weak         | ( )    | ( )    |

Is there a warning before the seizure?

|  | Type 1 | Type 2 |
|--|--------|--------|
| nausea                                     | ( )    | ( )    |
| nervousness                                | ( )    | ( )    |
| headache                                   | ( )    | ( )    |
| shaking of arm or leg                      | ( )    | ( )    |
| numbness of arm or leg                     | ( )    | ( )    |
| twitching of face                          | ( )    | ( )    |
| change in mood or behavior                 | ( )    | ( )    |
| feeling as if something is about to happen | ( )    | ( )    |
| peculiar sensation in stomach              | ( )    | ( )    |
| head or other part of body                 | ( )    | ( )    |
| other _____                                | ( )    | ( )    |

Which medications are you now taking or have you taken for the seizures?

|               | Present | Past | Dosage |
|---------------|---------|------|--------|
| Dilantin      | ( )     | ( )  | _____  |
| Phenobarbital | ( )     | ( )  | _____  |
| Tegretol      | ( )     | ( )  | _____  |
| Depakene      | ( )     | ( )  | _____  |
| Depakote      | ( )     | ( )  | _____  |
| Zarontin      | ( )     | ( )  | _____  |
| Mysoline      | ( )     | ( )  | _____  |
| Lamictal      | ( )     | ( )  | _____  |
| Neurontin     | ( )     | ( )  | _____  |
| Felbatol      | ( )     | ( )  | _____  |
| Tranxene      | ( )     | ( )  | _____  |
| Topamax       | ( )     | ( )  | _____  |
| Gabitril      | ( )     | ( )  | _____  |
| Valium        | ( )     | ( )  | _____  |
| Zoregran      | ( )     | ( )  | _____  |
| Keppra        | ( )     | ( )  | _____  |
| Other         | ( )     | ( )  | _____  |

**FAINTING** (brief loss of consciousness)

1. When was the first time you fainted: Month/Year \_\_\_\_\_
2. How long does the period of unconsciousness last? \_\_\_\_\_  
( ) a few seconds                      ( ) a few minutes                      ( ) longer than a few minutes
3. How often do you experience this?  
( ) more than once a day                      ( ) 2-3 times a month                      ( ) 2-3 times a year  
( ) once a day                      ( ) once a month                      ( ) once a year  
( ) 2-3 times a week                      ( ) every other month                      ( ) less than once a year  
( ) once a week
4. Have these recently?  
( ) increased in frequency or duration                      ( ) decreased in frequency or duration  
( ) remained about the same
5. Do you have a warning before you faint?  
( ) lightheadedness      ( ) spinning feeling      ( ) headache      ( ) nausea      ( ) weakness  
( ) other \_\_\_\_\_
6. Does anything bring on the faintness or fainting?  
( ) emotional stress      ( ) physical stress      ( ) trauma, fright      ( ) suddenly arising from a lying position  
( ) the sight of blood      ( ) other \_\_\_\_\_
7. Do any of the following symptoms accompany the spells?  
( ) biting tongue                      ( ) visual or hearing disturbance                      ( ) dizziness  
( ) shaking of arms or legs                      ( ) numbness or tingling                      ( ) headache  
( ) sweating                      ( ) loss of urine                      ( ) weakness  
( ) nausea or vomiting                      ( ) paleness                      ( ) other symptoms
8. How do you feel when you regain consciousness?  
( ) generally weak      ( ) sleepy      ( ) headache      ( ) normal      ( ) other \_\_\_\_\_
9. Can you prevent yourself from fainting?  
( ) by lying down      ( ) by willpower      ( ) medication      ( ) other \_\_\_\_\_
10. Have you ever injured yourself during one of these episodes? \_\_\_\_\_
11. Have you ever been hospitalized because of the episodes? \_\_\_\_\_

## SHAKING OR ABNORMAL MOVEMENTS

1. When did the tremor, shaking or abnormal movements begin? Month/Year \_\_\_\_\_
2. Which part of the body is involved?
- right arm                       left arm                       face                       neck  
 right leg                       left leg                       head                       whole body
3. Do you have any of the following movements?
- eye blinking                       shoulder shrugging                       patting or rubbing                       body jerking  
 head turning                       facial grimacing                       arm or leg jerking                       other
4. Do you make any of the following noises or vocalizations?
- throat clearing                       sniffing                       puffing                       sounds                       swear words  
 grunting                       honking                       clicking                       words                       other
5. Do any of these symptoms accompany the movements?
- tightening of muscles                       slowness of movement  
 slurring of speech                       weak volume of speech
6. Do the movements occur:
- at rest                       during some activity                       during sleep
7. Does anything aggravate or bring on the movements?
- emotional stress     medication     sudden body movements     physical stress     rest  
 other factors \_\_\_\_\_
8. Does anything prevent the movements?
- rest and relaxation                       medication                       other \_\_\_\_\_
9. Do the movements occur?
- continuously                       for minutes at a time                       for seconds at a time                       for days at a time
10. Do the movements occur?
- more than once a day                       two or three times a month                       two or three times a year  
 once a day                       once a month                       once a year  
 several times a week                       every other month                       less than once a year  
 once a week
11. Have the movements been getting?
- more severe                       more frequent                       less severe                       less frequent  
 longer in duration                       more intense                       shorter in duration                       less intense
12. What medications or other treatments have been tried? \_\_\_\_\_
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## HEADACHES

1. Do you have more than one headache type?      Yes      No

If yes, answer questions below for the most severe headache type

2. When did these headaches begin?    Month \_\_\_\_\_    Year \_\_\_\_\_

3. Was there a precipitating event for the headaches?      Yes      No

trauma                       changes in the family                       other  
 school problem             death of relative or friend             \_\_\_\_\_

4. What is the quality of the headaches?

pressure             throbbing             burning             vague ache             pounding  
 sharp                 band-like ache         stabbing             pulsating             other \_\_\_\_\_

5. Where is the location of the headaches?

right side             forehead             over temples             in front of ears             other  
 left side             behind eyes             back of head             top of head

6. How long does the average headache last?

less than 1 hour             4-8 hours             1-3 days  
 1-3 hours             9-24 hours             constant

7. How often do you have the headaches?

several times a day             3-4 times a week             once a month  
 once a day             1-2 times a week             2-10 times a year  
 5-7 times a week             2-4 times a month             less than once a year

8. Are you having the headaches more frequently?      Yes      No

9. Are the headaches becoming more severe?      Yes      No

10. When do you have the headaches?

wake up with headache     in the middle of the night     weekends     spring  
 in the morning             summer             weekdays  
 in the afternoon             fall  
 in the evening             winter

11. Which of the following may trigger a headache?

lack of sleep             anxiety             fasting             hot dogs, salami  
 tiredness             excitement             alcohol             Chinese food  
 exercise             travel             chocolate             other food  
 stress             bright lights             cheeses             menstruation  
 change in weather

12. Do you have a warning that a headache is coming?      Yes      No

If yes, please specify: \_\_\_\_\_  
\_\_\_\_\_

13. What do you do when you develop a headache at school or work? \_\_\_\_\_  
\_\_\_\_\_



When did you first become concerned about problems with your child's development, learning or behavior?

Child's age \_\_\_\_\_

| Does your child have any of the following:  | not a problem | mild | moderate | severe |
|---|---------------|------|----------|--------|
| Fidgety                                     |               |      |          |        |
| Very active                                 |               |      |          |        |
| Daydreams                                   |               |      |          |        |
| Distractible                                |               |      |          |        |
| Short attention span                        |               |      |          |        |
| Excitable                                   |               |      |          |        |
| Impulsive                                   |               |      |          |        |
| Loud  |               |      |          |        |
| Fails to finish things that he starts       |               |      |          |        |
| Frustrates easily                           |               |      |          |        |
| Childish and immature                       |               |      |          |        |
| Does not get along well with other children |               |      |          |        |
| Denies mistakes or blames others            |               |      |          |        |
| Argumentative                               |               |      |          |        |
| Mood changes quickly and drastically        |               |      |          |        |
| Overly sensitive to criticism               |               |      |          |        |
| Temper outbursts                            |               |      |          |        |
| Unpredictable behavior                      |               |      |          |        |
| Demands must be met immediately             |               |      |          |        |
| Defiant                                     |               |      |          |        |
| Refuses to follow rules                     |               |      |          |        |
| Swears or uses obscene language             |               |      |          |        |
| Lies  |               |      |          |        |
| Steals                                      |               |      |          |        |
| Sexually aggressive/abusive                 |               |      |          |        |
| Physically abusive to others                |               |      |          |        |
| Physical abusive to animals                 |               |      |          |        |
| Trouble with police                         |               |      |          |        |
| Runs away from home                         |               |      |          |        |
| Lack of awareness of others                 |               |      |          |        |
| Insists on routines followed exactly        |               |      |          |        |
| Preoccupied with one subject                |               |      |          |        |
| Repetitive movements                        |               |      |          |        |
| Repetitive behaviors                        |               |      |          |        |
| Sleep problems                              |               |      |          |        |
| Slow in language development                |               |      |          |        |
| Speech Problem                              |               |      |          |        |
| Clumsiness                                  |               |      |          |        |
| Poor handwriting                            |               |      |          |        |
| Reading problems                            |               |      |          |        |
| Trouble with math                           |               |      |          |        |

**Has your child:**

**Yes**

**No**

Undergone psychological or educational testing of abilities?

( )

( )

If yes, please try to bring the results with you or have them sent to us.

Received psychological counseling?

( )

( )

Any relatives with similar problems?

( )

( )

What are your thoughts about what is causing the problems in your child? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Dear Teacher:

\_\_\_\_\_ is a patient under my care. Would you please complete this questionnaire and return it to me. It will help in making decisions for medical management. In advance, I thank you very much.

Sincerely yours,

Morris Kinast, M.D.

Date of Evaluation \_\_\_\_\_ Name of Teacher \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

|  | Not at all | Just a little | Pretty much | Very much |
|--|------------|---------------|-------------|-----------|
| 1. Restless in the "squirmy" sense.              |            |               |             |           |
| 2. Makes inappropriate noises when he shouldn't. |            |               |             |           |
| 3. Demands must be met immediately.              |            |               |             |           |
| 4. Acts "smart" (impudent or sassy).             |            |               |             |           |
| 5. Temper outbursts and unpredictable behavior.  |            |               |             |           |
| 6. Overly sensitive to criticism.                |            |               |             |           |
| 7. Distractable, short attention span.           |            |               |             |           |
| 8. Disturbs other children.                      |            |               |             |           |
| 9. Daydreams.                                    |            |               |             |           |
| 10. Mood changes quickly and drastically.        |            |               |             |           |
| 11. Quarrelsome.                                 |            |               |             |           |
| 12. Restless. always "up and on the go."         |            |               |             |           |
| 13. Excitable, impulsive.                        |            |               |             |           |
| 14. Excessive demands for teacher's attention.   |            |               |             |           |
| 15. Appears to be unaccepted by group.           |            |               |             |           |
| 16. Fails to finish things that he starts.       |            |               |             |           |
| 17. Childish and immature.                       |            |               |             |           |
| 18. Denies mistakes or blames others.            |            |               |             |           |
| 19. Does not get along well with other children. |            |               |             |           |
| 20. Frustrates easily.                           |            |               |             |           |
| 21. Uncooperative with teacher.                  |            |               |             |           |
| 22. Difficulty in learning.                      |            |               |             |           |

COMMENTS:

Please return to: Morris Kinast, M.D.  
NeuroCare Center, Inc.  
4105 Holiday Street, N.W.  
P.O. Box 35006  
Canton, Ohio 44735

Thank You.