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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)

<input type="checkbox"/> Observation	<input type="checkbox"/> Hands on	<input type="checkbox"/> Video
<input type="checkbox"/> Written materials	<input type="checkbox"/> One-on-one	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Listening	<input type="checkbox"/> 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