

The Children's Hospital Neurology Department

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Name of child/Patient _____ Birthdate _____

Name of Person Completing Form _____ Relationship _____

What do you feel is the main issue? _____

PREGNANCY HISTORY: Age of mother at delivery: _____ Number of Pregnancies before this: _____

Did any of the following happen?

- Bleeding Yes No
- Infection Yes No
- Prenatal Testing Yes No
- X-rays Yes No
- Illness Yes No

Birth History: Weight at birth: _____

- Was the baby:
- Full term Yes No
 - Born Vaginally Yes No
 - Breathing Right Away Yes No

Was there use of:

- Medication Yes No
- Alcohol Yes No
- Drugs Yes No
- Tobacco Yes No

Did the baby have:

- Medications Yes No
- Oxygen Yes No
- Jaundice Yes No
- Feeding Problems Yes No
- Seizures Yes No
- Other Problems Yes No

DEVELOPMENT: Please give the age when your child did the following:

- | | | |
|------------------|-----------------------------|-----------------------------|
| ____ Rolled over | ____ Coo | ____ Transferred toy one |
| ____ Sat alone | ____ Laughed | hand to the other |
| ____ Crawled | ____ Said 'mama' or 'dada' | ____ Fed self cracker |
| ____ Walked | ____ Put two words together | ____ Potty trained by day |
| | | ____ Potty trained by night |

Name of school: _____

Grade: _____

- Regular Classes Yes No
- Special Classes Yes No
- Special Classes in past Yes No IEP Yes No

BEHAVIOR CONCERNS

- Short attention span Yes No
- Depression Yes No
- Hurts self Yes No
- Hurts others Yes No
- Trouble with the law Yes No

Did your child have a hand preference Before 12 months of age? Yes No

MEDICAL HISTORY:

Allergies: _____

Current medications: _____

Hospitalizations: _____

Surgeries: _____

Serious Accidents: _____

Medications taken in the past (name and amount): _____



Are child's immunizations up to date? Yes No

Does child complain of anything daily or weekly? Yes No

If yes, please describe: _____

Does your child have problems with any of the following?

Ongoing or Serious Illness	Yes	No	Lungs	Yes	No
Growth	Yes	No	Stomach	Yes	No
Skin	Yes	No	Bowel or Bladder	Yes	No
Eyes	Yes	No	Muscles or bones	Yes	No
Ears, Nose, Mouth	Yes	No	Blood or Immune System	Yes	No
Heart	Yes	No			

If yes, please describe: _____

List any other health care provider who sees your child: _____

Tests your child has had done and the dates done:

EEG: _____ MRI: _____ CT: _____

LABS: _____ VISION: _____ HEARING: _____

FAMILY MEDICAL HISTORY: List any relative with the following:

Seizures/Epilepsy _____ Tics/Unusual movements _____ Birth Defects _____
 Learning Problems _____ Severe/Migraine headaches _____ Alcohol/drug abuse _____
 Mental retardation _____ Mental Illness _____ Other _____

SOCIAL HISTORY:

Child lives with Natural Parents One Parent Parent and Step Parent
 Legal Guardian Adoptive parents Other: _____

Natural Father's: Age: _____ Education Level _____ Occupation _____

Natural Mother's: Age: _____ Education Level _____ Occupation _____

Step-father/Adoptive Father: Age: _____ Education Level _____ Occupation _____

Step-Mother/Adoptive Mother: Age: _____ Education Level _____ Occupation _____

Other children (name and age) _____

Any problems with other children? _____



The Children's Hospital
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and Health Sciences Center