Melissa Przeklasa Auth, M.D.
30131 Town Center Drive Suite # 195
Laguna Niguel, CA 92677
Office: (949) 495-6100
Fax: (949) 354-0612
occhildneurology.com
occhildneuro@gmail.com

Parent Questionnaire

*PLEASE COMPLETE IN **BLACK INK***

Patient Name:	Date of Birth:

Form Completed By: Mother ____ Father____ Other: _____

Referring Physician: _____

Child Profile

What concerns do you have about your child: (please a brief summary of the main concerns)?
When were the problems first noticed? Have they progressed? How have they been handled so far?

What has your child been told about coming for this evaluation?

Past/Current Treatment History

Please list or describe any chronic medical problems (asthma, diabetes, developmental delays, etc).
Please describe any major illnesses, surgeries, or hospitalizations.

Is your child currently taking any medications (including supplements/vitamins)? No__ Yes__ If yes, specify:

Does your child have any allergies? No __ Yes __ If yes, specify:

Are your child's immunizations up to date? Yes __ No __ If no, please explain:

Has your child had vision and hearing screening performed either by your physician at the school? If yes, please specify when, by whom and results:

Has your child had previous neurological, developmental/behavioral, psychological, or psychiatric evaluations and/or treatment (e.g., medication, counseling, tutoring, speech, physical or occupational therapy, not described above and by whom?

Patient Name:	Date of Birth:

Birth History

Was your child born two or more weeks before the "due date"? No_____ Yes _____

If yes, how many weeks early was your child born? _____ weeks early

How much did your child weigh at Birth _____

Biological Father's age at birth of your child _____ Biological Mother's age at birth of your child _____

Number of pregnancies prior to this child _____ Number of miscarriages prior to this child _____

Were there any problems during the pregnancy, labor/delivery or following the birth? No _____ Yes _____

If yes, please specify:

Was your child born by C-Section? No _____ Yes _____

If yes, please specify why:

Were any substances or medication used by the mother during the pregnancy? No_____ Yes_____

If yes, please specify (e.g., prescription medication, alcohol, tobacco, etc.)'

Developmental History:

(Please *write in* age. Ages in *parenthesis* are *approximate normal limits.)*

Gross Motor:	***Fine Motor:***
Rolled over (4-5 mos) _____ Sat without support (6-7 mos) _____ Walked alone (12-16 months) _____ Runs (15-18 mos) _____ Catches a ball (3 years) _____ Hops on one foot 2-3 times (4 years) _____	Copies circle (3 years) _____ Copies Square (5 years) _____ Adaptive /Self help: Drinks from a cup (12 – 15 mos) _____ Uses a spoon (15-24 mos) _____ Undresses completely (3 years) _____ Dresses Completely (4 years) _____
Language Development:	***Social/Emotional Development***
Babbles (6 mos) _____ Understands “NO” (9-10 mos) _____ 3-5 word vocabulary (12 mos) _____ Follows 1 step command with gestures (12 mos) _____ Can point to several body parts (16-17 mos) _____ 2 word phrases (24 mos) _____ Follows 2 step command (24 mos) _____ 3 word sentences (3 years) _____	Temperament as a baby (e.g. easy, colicy): Shy with strangers (7-8 mos) _____ Plays cooperatively with peers (4 yrs) _____ Current temperament/mood (e.g. irritable, anxious, happy):

Are there any current problems or concerns with development not mentioned already?

Patient Name:	Date of Birth:

Patient Review of Systems

Has your child had any problems mentioned below that you haven't already described?

	Y	N	Explain
Weight loss or gain			
Weakness			
Rash			
Itching			
Light or dark skin color changes			
Changes in hair growth or loss			
Headaches			
Double vision			
Neck stiffness or pain			
Chest pain			
Palpitations			
Fainting/passing out			
Heart murmurs			
Shortness of breath			
Wheezing			
Appetite changes			
Indigestion/reflux			
Nausea, vomiting or diarrhea			
Recent changes in bowel habits			
Change in urinary frequency			
Bed wetting			
Problems with menstruation			
Joint pain, swelling or redness			
Convulsions			
Staring spells			
Tremor			
Incoordination (ataxia, tremor)			
Anxiety / Depression			
Anemia			
Bleeding Tendency			
Previous Blood Transfusions			
Lymph node enlargement or tenderness			

Patient Name:	Date of Birth:

Family Medical History (other than patient)

Please include all pertinent **FAMILY history** for first and second-generation **FAMILY members**.

	Y	N	Family Member's relationship to child
Trouble learning to read			
Trouble with arithmetic			
Trouble with writing			
Attention Deficit/Hyperactivity disorder			
Other school problems			
Speech problems			
Language delay			
Behavior problem in childhood			
History of physical or emotional abuse			
Depression			
Anxiety/Phobia/panic disorders			
Other Mental illness			
Drinking problems			
Drug Abuse			
Seizures			
Mental Retardation			
Autism			
Headaches/Migraines			
Tourette Syndrome			
Neurologic Conditions			
Congenital Anomalies			
Diabetes			
High blood pressure			
Irregular Heartbeat or rhythm			
Heart attack before 40 years old			
Thyroid condition			
Deafness			
Blindness			
Any other disorders in the family			

Patient Name:	Date of Birth:

Social history

Child's School: _____ City: _____

Teacher's Name: _____ Grade: _____

Type of Classroom: Regular ____ RSP____ Special Day Class _____

IEP:_____

This child is currently living with:

__ Biological mother and biological father

__ Biological mother

__ Biological father

__ Adoptive parents. Is your child aware that he/she is adopted? _____

__ Foster parents

__ Other (specify) _____

The biological parents of this child are currently:

__ Married to each other (Years married: ___)

__ Divorced from each other

__ Separated from each other

__ Never married to each other

Please list all people who are currently living in this child's household (name, age, and relationship to child):

Name	Age	Relationship

Other Concerns

Are you concerned about issues not covered in this questionnaire? Please describe:

Thank you for completing this questionnaire. It will be reviewed as a valuable first step in evaluating your child.