Carolinas Pediatric Neurology Care

Uncompromising Excellence. Commitment to Care.

FAMILY INFORMATION SLIP

One form may be used for the entire family provided that the responsible party is the same for each child.

Today's Date: ______________

CHILDREN'S NAMES:

LAST	FIRST	MIDDLE	SEX	DATE OF BIRTH

PT. ADDRESS: ______________________________ **HOME PHONE#:** ______________ **CELL #:** ______________

______________________________ **E-MAIL ADDRESS:** ______________________________

FATHER'S/ALTERNATE PARENT NAME: ______________________ **DOB:** ______________ **SS#:** ______________

ADDRESS (if different): ______________________________ **CITY/STATE/ZIP:** ______________________

HOME PHONE#: ______________ **EMPLOYER:** ______________________________ **WORK #:** ______________

MOTHER'S/ALTERNATE PARENT NAME: ______________________ **DOB:** ______________ **SS#:** ______________

ADDRESS (if different): ______________________________ **CITY/STATE/ZIP:** ______________________

HOME PHONE#: ______________ **EMPLOYER:** ______________________________ **WORK #:** ______________

IF DIVORCED OR SEPARATED, LIST CUSTODIAL PARENT/ LEGAL GUARDIAN: ______________________________

WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY? ______________________ **PHONE#:** ______________

Is there anyone that is court ordered that should not have contact with your child? If so, please provide us with these legal documents.

As a parent, I understand I must give my permission for my child to receive medical treatment. If at all possible, I will come with my child for every appointment at the CAROLINAS PEDIATRIC NEUROLGY CARE.

If I cannot come with my child, I agree to let ______________________ **and/or** ______________________
(Name & Relationship) **(Name & Relationship)**
give permission for any treatment. (Examples of persons to name here may be stepparent, grandparent, sitter, etc.)

If my child comes with anyone other than myself or the persons listed above, I agree to send with them a written note, with my signature, giving permission for treatment.

**** Child must be 18 years of age to be treated without a parent present or to pick up a prescription.****

______________________ ______________________ ______________ ______________

Patient Signature **(Date)** **Responsible Party Signature** **(Date)** **Initials**

Signature also required on other side

Due to the high volume of patients needing pediatric specialist services and the importance of attending all scheduled visits, Carolinas Pediatric Neurology Care has established the following guidelines regarding cancelled, no showed, and late appointments.

Cancel/No Show Policy

1. Patients/guarantors must notify Carolinas Pediatric Neurology Care at 704-403-2660 within 24 hours of their scheduled appointment if they need to cancel an appointment. This allows the clinic to schedule another patient in that time slot.
2. Patients/guarantors who do not call within 24 hours of their scheduled appointment and/or fail to show up for a scheduled appointment will be considered a "no show."
3. Patients/guarantors with 3 no shows for established patients, or 2 for new patients, within a rolling 12-month period will receive a certified letter in the mail, informing them of their discharge from the clinic due to excessive "no shows."

Late Policy

1. Patients who arrive at Carolinas Pediatric Neurology Care more than 10 minutes after their scheduled appointment time will be considered late.
2. Depending on the volume of the patients scheduled, late appointments may require the patient to:
   – wait until they can be worked back into the provider's schedule, or
   – reschedule for another date or time

Your cooperation is greatly appreciated.

I understand the above statements.

Signed: ______________________________

Date: ______________________________

Witness: ______________________________

Carolina Medical Center
Carolinas Pediatric Neurology Care
No Show/Late Policy

Patient Information or Sticker

Name:

DOB:

Medical Record#:

May 5, 2011

Carolinas Pediatric Neurology Care

Uncompromising Excellence. Commitment to Care.

Child's Name (Last name, First, MI)______________________________

Sex: Male / Female Date of Birth:____________

Who is your child's primary care provider/office? ________________________

Who has referred your child to see Carolinas Pediatric Neurology Care?________________

Do you have anyone else that you would like to receive a copy of today's consultation? If so, please list them below.

Name:____________________ Name:____________________

Address:__________________ Address:__________________

Phone:________ Fax:________ Phone:________ Fax:________

Parent/Guardian Name: ________________________ Date of Birth: __________

I consent to the release of my child's medical information from *Carolinas Pediatric Neurology Care* to the above listed physicians.

____________________ ____________ ______________

Signature Date Relationship to Patient

Special Assistance

Do you need a **Translator?** YES NO **LANGUAGE:** ______________

Special Accommodations? Please describe: ____________________________

Please list the main questions you would like us to attempt to answer:

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________

Please CIRCLE YES to any of the following conditions your child currently, or in the past, has experienced:

Condition

Headaches	YES	NO	Abnormal movements	YES	NO	Arm or leg weakness	YES	NO
Dizziness	YES	NO	Numbness sensations	YES	NO	Difficulty smelling	YES	NO
Memory loss	YES	NO	Difficulty walking	YES	NO	Hearing Problems	YES	NO
Bladder problems	YES	NO	Difficulty swallowing	YES	NO	Bowel problems	YES	NO
Vision problems	YES	NO	Vomiting	YES	NO	Speech problems	YES	NO
Blurring	YES	NO	Seizures	YES	NO	Arm/leg stiffness	YES	NO
Double vision	YES	NO	Personality Change	YES	NO	Tremors	YES	NO
Pain	YES	NO	Balance problems	YES	NO			

Other condition not listed: ____________________

Past Medical History

Has your child ever been **hospitalized overnight**, had any **operations**, **serious illnesses**, or suffered a **major head injury** (one where he/she lost consciousness)? Please provide all details: for example, how old was the child, where was he/she hospitalized, etc.

____

____

____

Please list **all** current medications and doses child is taking, including over-the-counter medications:

1. ____________ 4. ____________
2. ____________ 5. ____________
3. ____________ 6. ____________

Please list **all medication allergies**; please provide details about what happened when medication was given:

____

____

Are your child's immunizations up to date? Yes ____ No____

Other than the child seen today does anyone in the family have any of these conditions? Please state **who** has the condition.

Epilepsy/seizures without fever	yes/no	who______	Learning disabilities	yes/no	who______
Seizures with fever	yes/no	who______	ADD/ ADHD	yes/no	who______
Severe headaches	yes/no	who______	Fainting spells	yes/no	who______
Migraines	yes/no	who______	Nerve or muscle disease	yes/no	who______
Cerebral palsy	yes/no	who______	Early or sudden death	yes/no	who______
Tics or Tourettes Syndrome	yes/no	who______	Deafness	yes/no	who______
Birth defects	yes/no	who______	Paralysis, in a wheelchair	yes/no	who______
Slow defects	yes/no	who______	Psychiatric problems	yes/no	who______
Breath-holding spells	yes/no	who______	Mental Retardation	yes/no	who______

Pregnancy

Age of mother at delivery of patient: ______________ Number of prior pregnancies: ____________

Did mother receive regular prenatal care? Yes / No If yes, beginning of what month or pregnancy________

Were there any complications of pregnancy? Yes / No If yes, please explain: ___________________________

____

____

Please list any medications or drugs taken during pregnancy_______________________________________

____

Birth

Where was your child born? City: ___________________________ State: ______________________

Hospital: ____

Birth Weight: __________________

Method of delivery: **Vaginal** or **Cesarean Section**. If by Cesarean section, why? ____________________________

Head or bottom first? ___________________ Was there use of forceps / a vacuum or neither?__________________

Was the infant born prematurely? Yes ___, how early? ______________ No_____

After birth, did your child require or have issues with the following:

CPR or resuscitation after birth	yes/no	Special care or Intensive care nursery	yes/no
Antibiotics	yes/no	Ventilator (include length of time)	yes/no
Jaundice.. (phototherapy required)	yes/no	Blood transfusions	yes/no
Seizures	yes/no	Abnormal Brain Imaging	yes/no
Abnormal Movements or Weakness	yes/no	Birth Marks	yes/no
Deformities or Birth Defects	yes/no	Hydrocephalus	yes/no
Breathing issues	yes/no	Infections	yes/no
Seizures	yes/no	Feeding problems	yes/no
Paralysis	yes/no		

How long did your infant stay in the nursery? _________________________

Developmental History (please indicate age attained)

Gross Motor: Crawl _____ Walk _______ Hop _______ Pedal _______ Broad jump_______ Bike_______

Fine Motor: Transfer objects _______ Pincer grasp_______ Buttons/zippers_______ Tie shoe_______

Language/Social: Smile ____ 1st word ____ 2 word phrase ____ Colors____ ABC's ____ reading ____

Adaptive: Self-feed ____ Potty train ____ Dress self ____

List Previous Developmental or Behavioral Diagnosis: ____

Has your child had a previous CDSA, Early Intervention, or School Learning evaluation? Yes / No

If so, please provide details below and bring a copy to the visit. ____________________

____

Do they receive special services, physical, speech, or occupational therapies? Yes / No

____

Has the child's intelligence or development ever been tested? Yes / No

If yes by whom, where and when: ____________________

____

Does the child have special adaptive equipment? Please list below:

_____ Orthotics _____ Walker _____ Stander _____ Manual/motorized wheelchair _____ Lift

Identify any current stressors related to the child's care:

____

____

Social History

Where does the child currently go to school or daycare? ____________________

What is the current grade level? _________ Has your child ever repeated a grade? If so, which grade? _________

Does the child require a special classroom? Yes / No

Who does the child live with? Please list all adults and children who live in the same house and their relationship to the patient.

____

____

____________________ ____________________
Parent/Guardian Signature Date

____________________ ____________________
Physician Signature Date

Thank you for taking the time to complete this medical questionnaire. This information is important to the evaluation and treatment of your child and will help to facilitate your visit.

Carolinas Pediatric Neurology Care

Uncompromising Excellence. Commitment to Care.

Please check all that apply:

PATIENT'S NAME: ______________________________ **DOB:** ____________

General	Yes	No
Weight loss or gain	☐	☐
Change in appetite	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Excessive sleepiness	☐	☐
Inability to sleep	☐	☐
Neurological		
Headache	☐	☐
Numbness	☐	☐
Tingling	☐	☐
Poor balance	☐	☐
Falls	☐	☐
Loss of consciousness	☐	☐
Dizziness	☐	☐
Trouble speaking	☐	☐
Eyes		
Visual loss	☐	☐
Double vision	☐	☐
ENT		
Trouble swallowing	☐	☐
Sinusitis	☐	☐

Heart	Yes	No
Palp./Heart racing	☐	☐
Chest pain	☐	☐
Fainting spells	☐	☐
Leg swelling	☐	☐
Respiratory		
Cough	☐	☐
Shortness of breath	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Endocrine		
Diabetes	☐	☐
Thyroid disease	☐	☐
High cholesterol	☐	☐
Musculoskeletal		
Joint pain or swelling	☐	☐
Neck or back pain	☐	☐
Muscle aches/cramps	☐	☐
Weakness	☐	☐
Immune/Allergy		
Allergy to medication	☐	☐
Sneezing	☐	☐

Genitourinary	Yes	No
Bladder/bowel control	☐	☐
Frequent urination	☐	☐
Urinary urgency	☐	☐
Sexual dysfunction	☐	☐
Gastrointestinal		
Nausea/vomiting	☐	☐
Diarrhea	☐	☐
Ulcers	☐	☐
Constipation	☐	☐
Hematological		
Bleeding	☐	☐
Bruising	☐	☐
Use of blood thinners	☐	☐
Skin		
Rashes	☐	☐
Itching	☐	☐
Psychiatric		
Depression	☐	☐
Anxiety	☐	☐
Memory Loss	☐	☐
Sadness	☐	☐

Patient or Guardian: ______________________________ **Date:** ____________

Physician: ______________________________ **Date:** ____________

Carolinas Pediatric Neurology Care

Uncompromising Excellence. Commitment to Care.

GENERAL QUESTIONS

1. When did these headaches start?

   (Month/Year): _ _ /_ _ _ _

2. In the past 4 weeks, how frequent were the headaches?

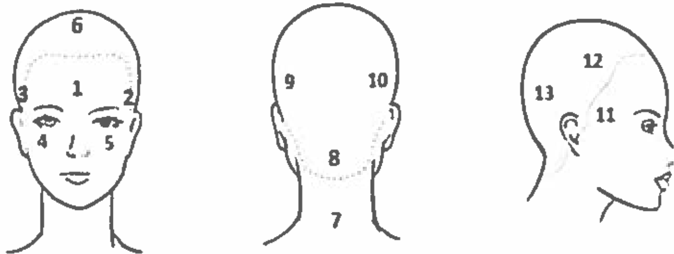
   ☐ Daily ☐ Weekly ☐ 2-3 times

3. How long do the headaches last?

   ☐ A few minutes ☐ 1-3 hours

   ☐ 30 min-60 min ☐ Most of the day

4. Circle where the pain is the worst:



5. Rate your child's pain on average: (circle one)

   (Not bad) 1 2 3 4 5 6 7 8 9 10 (Worst pain ever)

6. Describe the pain

   ☐ Dull, Achy ☐ Pounding ☐ Pulsing ☐ Burning

7. Did the headaches start with a specific illness/injury?

   ☐ No ☐ Yes If yes, describe:______________________

   ____

8. Have you noticed a pattern to the headaches?

   ☐ No ☐ Yes If yes, describe:______________________

   ____

9. Any symptoms associated with the headaches?

   ☐ Light Sensitivity ☐ Sound Sensitivity

   ☐ Nausea ☐ Vomitting

   ☐ Numbness/tingling ☐ Fainting

   ☐ Visual Disturbances ☐ Other_______________

10. **FEMALES:** Are the headaches associated with menstrual cycle? ☐ Yes ☐ No

11. Since starting, the headaches have (circle):

    Increased / Decreased / Not changed IN SEVERITY

    Increased / Decreased / Not changed IN FREQUENCY

    Increased / Decreased / Not changed IN DURATION

12. How many days of school has the child missed due to headaches this school year? ____________________

TREATMENT

13. My child has had tests for headaches (check all that apply):

    ☐ MRI ☐ CT Scan

    ☐ Allergy Testing ☐ Eye Exam

    ☐ Dental Exam ☐ Other_______________

14. Is there a FAMILY HISTORY of:

    ☐ Migraines ☐ Seizures ☐ Stroke in children

    ☐ Depression ☐ Anxiety ☐ Motion sickness

15. What medications/treatments have you tried so far prescriptions, over-the-counter, herbal, home remedies)?

    ____

SLEEP

16. My child sleeps well most nights:

    ☐ No ☐ Yes If yes, continue to next section.

17. My child has trouble:

    ☐ Falling asleep ☐ Staying asleep ☐ Both

18. Did your child have trouble sleeping before headaches?

    ☐ Yes ☐ No

19. Does your child sleep in your bed?

    ☐ Never ☐ Occasionally ☐ Frequently

20. During sleep, does your child:

    ☐ Snore ☐ Grind teeth ☐ Walk ☐ Talk

21. Does the pain arouse the child from sleep?

    ☐ Never ☐ Occasionally ☐ Frequently

22. My child usually falls asleep at _____ (time) and awakens at _____ (time).

Carolinas Pediatric Neurology Care

Uncompromising Excellence. Commitment to Care.

NUTRITION

23. Is your child overweight? ☐ Yes ☐ No

24. My child eats breakfast ____ days per week.

Typical breakfast is: ______________________________

____

25. My child eats well-balanced meals/snacks:

☐ Yes ☐ No

26. My child skips meals often: ☐ Yes ☐ No

27. On average, my child drinks:

____ glasses of water ____ glasses of caffeinated drinks

Other beverages: ______________________________

LIFESTYLE

28. My child lives at home with (circle all that apply):

Biological Father   Biological Mother   Siblings

Grandmother   Grandfather   Cousins

Adoptive parents   Other: ____________________

29. Any problems or stress with:

☐ School ☐ Home ☐ Friends

Please describe______________________________

30. Does your child have a history of behavior or emotional problems? ☐ No ☐ Yes

If yes, please describe: ______________________________

____

31. My child uses the computer/TV/cell phone:

_____hours/day at home _____ hours/day at school

32. How many hours per day does your child engage in physical activity? ______ hrs/day. What does the usual physical activity include?______________________________

____

33. What extracurricular activities in your child involved in?

____

____

VISION

34. Does your child experience any:

☐ Double vision ☐ Dots or lines in vision

☐ Other vision problems, please describe:

____

____

35. Does your child wear:

☐ Glasses ☐ Contacts

36. When was their last vision check?

____