Child Neurology
Consultants of Austin

Established Patient Intake Form

Patient Name: ____ Date of Birth: ___________________

Parent/Guardian Name: ________________________________ Relationship to Patient: __________________

Pediatrician/PCP Name: _______________________________ Pediatrician Phone: ______________________

Preferred Pharmacy: ___________________________________ Pharmacy Phone: ______________________

Chief Complaint/Reason for the Visit:

Current Medications (please ask for a printed list from our system to correct):

Medication	Dosage (# cap/tab/mL)	How often?

Allergies (please list any to medications or other):

Review of Systems (please circle any symptoms that your child has today for the visit):

1. *General*: weight loss weight gain appetite loss appetite increase fever decreased energy

2. *Cardiovascular*: palpitations leg swelling fast heart rate chest pain high/low blood pressure

3. *Respiratory*: wheezing shortness of breath cough

4. *Gastrointestinal*: nausea vomiting constipation diarrhea jaundice abdominal pain blood in stool

5. *Genitourinary*: blood in urine pain during urination need to urinate suddenly odor in urine cloudy urine increased urination decreased urination urine incontinence

6. *Musculoskeletal*: weakness joint pain joint swelling muscle pain stiff neck

7. *Skin*: rash dry skin excessive sweating itching skin lesions hair loss excessive body hair acne

8. *Neurological*: headache tingling numbness seizures difficulty with balance dizziness fainting trembling or shaking (tremor) snoring excessive sleepiness difficulty falling asleep blurred vision double vision ringing in the ears head injury slurred speech difficulty finding desired words memory lapses or loss abnormal movements

9. *Psychological*: behavior as expected for age depressed anxiety behavior issues mood swings irritability aggression poor school performance daydreaming

10. *Endocrine*: frequent urination excessive drinking of fluids heat/cold intolerance breast buds menstrual cycle irregularity heavy menstrual periods

11. *Hematologic*: bruising bleeding nosebleeds gums bleeding swollen glands

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Social History:

Therapies: (indicate # of sessions/week):

OT ________ hours, _______ days/week
PT _______ hours, _______ days/week
ST _______ hours, _______ days/week
ABA _______ hours, _______ days/week

Aqua therapy _______ hours, _______ days/week
Hippo therapy _______ hours, _______ days/week
Behavioral _______ hours, _______ days/week
Other _______ hours, _______ days/week

Grade in school: ____________ Education: regular special inclusion homeschooled

Please circle any school problems with: reading motivation behavior peer relationships

Who lives at home with your child? (adults, children, pets…)

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Does anyone smoke around the child?____

Are there any updates to your past medical history or surgical history since your last visit?

Additional information and questions:

Provider Signature of Review:____ Date:____________________