Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Athens Concussion & Neuropsychology Center

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| **Background Information:** |
| Child`s Name: | Birth Date:  |
| Sex: 🞎 M 🞎 F  | Gender: 🞎 M 🞎 F 🞎 Neutral | Age:  | Grade: |
| Parent Name: | Parent Name: |
| **Why are you seeing us today?** |
|  |
| **When did the problem start?** |
|  |
| **Has your child been given a diagnosis? Please list if applicable.** |
|  |
| **Has your child been treated (help or tutoring) for the problem(s)?** |
| Date(s): |
| Treatment(s): |
| Date(s): |
| Treatment(s): |

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| **Questions:** |
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| **Birth History:** |
| Birth weight: | 🞎 Vaginal 🞎 C-Section  | Premature: 🞎 Yes 🞎 No |
| Gestational weeks: | Length in hospital: | Born in US: 🞎 Yes 🞎 No |
| Were there any abnormalities on the newborn screening? 🞎 Yes 🞎 No 🞎 Unsure |
| Any fetal exposure to drugs, tobacco, or alcohol? 🞎 Yes 🞎 No 🞎 Unsure |
| Any problems during pregnancy? 🞎 Yes 🞎 No Explain: |
| Did your baby require special care? 🞎 Yes 🞎 No Explain: |
| Child`s Ethnicity: 🞎 Hispanic or Latino 🞎Not Hispanic or Latino |
| Child`s Race: 🞎 Black 🞎 White 🞎 Asian 🞎 Pacific Islander 🞎 American Indian/Alaskan |

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| **Past medical history: Does your child have any problems with:** |
| **Problem** | **Yes** | **No** | **Explain** |
| Depression |  |  |  |
| Anxiety |  |  |  |
| Sleep |  |  |  |
| Self-Stimulating Behavior |  |  |  |
| Self-Harm |  |  |  |
| Obsessions |  |  |  |
| Compulsions |  |  |  |
| Neurological  |  |  |  |
| Seizures |  |  |  |
| Heart |  |  |  |
| Lungs/Asthma |  |  |  |
| Stomach |  |  |  |
| Kidneys |  |  |  |
| Urinary Tract |  |  |  |
| Muscles/Joints |  |  |  |
| Eyes/Vision |  |  |  |
| Allergies |  |  |  |
| Infections |  |  |  |
| List names of any steroids taken in the past 12 months:  |

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| **Surgical/Hospitalization History:** |
| Surgery: | Date/Reason: |
| Surgery: | Date/Reason: |
| Surgery: | Date/Reason: |
| Hospitalization: | Date/Reason: |
| Hospitalization: | Date/Reason: |
| Hospitalization: | Date/Reason: |

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| **Family History:** |
| Birth Mother: | Age: | Height: | Current Health: |
| Birth Father: | Age: | Height: | Current Health: |
| **Condition** | **Yes** | **No** | **Father** | **Mother** | **Sibling** | **Paternal** **Grandparent** | **Maternal****Grandparent** |
| Neurological Disease |  |  |  |  |  |  |  |
| Seizures |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |
| Anxiety |  |  |  |  |  |  |  |
| OCD |  |  |  |  |  |  |  |
| ADHD |  |  |  |  |  |  |  |
| Autism Spectrum Disorder |  |  |  |  |  |  |  |
| Hallucinations |  |  |  |  |  |  |  |
| Delusions |  |  |  |  |  |  |  |
| Suicide Attempt |  |  |  |  |  |  |  |
| Suicide Fatal |  |  |  |  |  |  |  |
| Parent 1 Occupation: | Parent 2 Occupation: |
| Is your child in daycare? 🞎 Yes 🞎 No  | Is your child in school? 🞎 Yes 🞎 No | Grade: |
| Your child`s grades: 🞎 A 🞎 B 🞎 C 🞎 D 🞎 Failing |
| Is your child missing school? 🞎 Yes 🞎 No  | How many days have been missed this term? |
| Does your child participate in PE class? 🞎 Yes 🞎 No |
| Does your child participate in any sports? 🞎 Yes 🞎 No | Sport(s): |
| What does your child do outside of school? |
| Who are the adults in the home? |
| Who are the children in the home? (List ages) |
| Smoking in the home? 🞎 Yes 🞎 No |
| Pets in the home? 🞎 Yes 🞎 No | Type: |
| Around animals? 🞎 Yes 🞎 No | Type: |
| Recent life changes? 🞎 Yes 🞎 No | Type: |

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| **Parent questions (circle the best answer)** |
| **1 = You think your child feels very bad, 10 = You think your child feels very good** |
| How did your child feel during the past week? 1 2 3 4 5 6 7 8 9 10 |
| How did your child feel during the past month? 1 2 3 4 5 6 7 8 9 10 |
| What is the best your child has ever felt? 1 2 3 4 5 6 7 8 9 10 |
| **Please list all food and drinks your child has had in the past 24 hours**  |
| Breakfast: |
| Lunch: |
| Dinner:  |
| Snacks: |

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| **Medications:** |
| **Prescription Name**  | **Dosage** | **Taken Today(Yes or No)** | **Frequency (how often is your child supposed to take it?)** | **How does your child take this medication** **(ex: by mouth, injection, etc.)** | **Why does your child take this medication** | **How often did your child take the medication last week?** |
|  |  |  |  |  |  | 🞎Not at all🞎1-2 days/week🞎3-4 days/week🞎5-6 days/week🞎Every Day |
|  |  |  |  |  |  | 🞎Not at all🞎1-2 days/week🞎3-4 days/week🞎5-6 days/week🞎Every Day |
|  |  |  |  |  |  | 🞎Not at all🞎1-2 days/week🞎3-4 days/week🞎5-6 days/week🞎Every Day |
|  |  |  |  |  |  | 🞎Not at all🞎1-2 days/week🞎3-4 days/week🞎5-6 days/week🞎Every Day |

Who filled out this form? 🞎 Patient 🞎 Parent 🞎 Guardian 🞎 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have reviewed the list above and, to the best of my knowledge, these are the medications the patient is currently taking.

