ANDREW MCINTOSH M.D.
CHILD NEUROLOGY

30131 Town Center Drive #195
Laguna Niguel, CA 92677
P: (949) 249-3780
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www.McIntoshNeurology.com

Parent Questionnaire

General Information

PLEASE COMPLETE IN BLACK INK

Date: _____

Form completed by: _____ Mother ____ Father ____ Other: _____

Parent's Occupations: _____

Child's Full Name: _____ Date of Birth: _____ Age: ____ Sex: ____

Home Address: _____

City: _____ Zip Code: _____

Home Phone: (_____)_____ Alternate Phone (_____)_____

Cell Phone: (_____)_____ Email Address: _____

Child's Legal Guardian: Mother ____ Father ____ Other: (specify) _____

Child's Primary Care Physician: _____

Physician's Phone Number: (_____)_____ Fax: (_____)_____

Who has referred this child: _____

Child Profile

What concerns do you have about your child: (please give 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 (e.g., asthma, diabetes, etc).

Please describe any major illnesses, surgeries, or hospitalizations.

Is your child currently taking any medications (including supplements)? No____ Yes____ If yes, please specify:

Does your child have any allergies? No ____ Yes ____ If yes, please 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 or 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, etc) not described above?

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? _____
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.)

All Developmental Milestones Normal? ***Yes*** ☐ ***No*** ☐ *Gross motor:* Rolled over (4 - 5 mos) ____ Sat without support (6 - 7 mos) ____ Walked alone (12-16 mos) ____ Runs (15-18 mos) ____ Catches a ball (3 years) ____ Hops on one foot 2 to 3 times (4 yrs) ____	*Fine motor:* Copies circle (3 yrs) ____ Copies square (5 yrs) ____ Any current problems or concerns? *Adaptive/self help:* Drinks from a cup (12 mos - 15 mos) ____ Uses a spoon (15-24 mos) ____ Undresses completely (3 yrs) ____ Dresses completely (4 yrs) ____
Language 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 (16-17mos) ____ 2-word phrases (24 mos) ____ Follows 2-step command (24 mos) ____ 3-word sentences (3 yrs) ____	*Social/Emotional Development:* Temperament as a baby (e.g. easy, colicky): Shy with strangers (7-8 mos) ____ Plays cooperatively with peers (4 yrs) ____ Current temperament/mood (irritable, anxious, happy):

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

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			
Exercise tolerance			
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			

Family Medical History

	Y	N	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			

Family Medical History (continued)

	Y	N	Relationship to Child
Anxiety/phobia/panic disorders			
Other mental illness			
Drinking problem			
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 that run in the family			

Social history

Child's School: _____ City: _____

Teacher Name: _____ Grade: ____

Type of Classroom: Regular ____ RSP____ Special Day Class ____

This child is currently living with:
____ Biological mother and biological father
____ Biological mother
____ Biological father
____ Adoptive parents
____ 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/**Current Patient to Dr. McIntosh?

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.

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Patient Name	Date of Birth

Financial Agreement

I understand that Dr. McIntosh is an "out-of-network provider" for all insurance plans (except Monarch HealthCare) and I am financially responsible for all charges incurred for services rendered.

Any "no shows" or cancellations with less than 24 hours notice will incur a fee equivalent to the scheduled appointment._____*(initial).*

Signature of Legal Guardian Date

Print Name of Legal Guardian

Authorization to Consent to Treatment of a Minor

I, the undersigned parent to: _____, a minor, do hereby authorize Andrew McIntosh, M.D., as agent for the undersigned to consent to any examination, medical diagnosis or treatment which is deemed advisable and to be rendered at the office.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

Signature of Legal Guardian Date

Print Name of Legal Guardian

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Andrew McIntosh, M.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Andrew McIntosh, M.D. describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Andrew McIntosh, M.D. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Office Manager; 30131 Town Center Drive #195; Laguna Niguel, CA 92677; (949)249-3780.

With this consent, Andrew McIntosh, M.D. may call, mail or email my home or other alternative location (including leaving a message on voice mail) in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Andrew McIntosh, M.D. may use my PHI for continuity and coordination of my treatment. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Our office may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

I have the right to request that Andrew McIntosh, M.D. restrict how he uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Andrew McIntosh, M.D. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Andrew McIntosh, M.D. may decline to provide treatment to me.

Signature of Legal Guardian Date

Print Name of Legal Guardian Date

Print Patient's Name Date