Children's Physician Group – Neurology
Children's Specialty Services
General Intake Form

Affix patient label here

Dear Parent:
Thank you for allowing us to care for your child. If you are receiving this form via email or mail, please complete it before your visit. If you have received this form on the day of your visit, please complete this form as you wait and let registration know once finished.

Please check all that apply when answering the questions below:

1. When did the event/symptom your child is experiencing start? (choose only one answer)
   ☐1 week ago ☐ Greater than 1 month ago ☐ Greater than 6 months ago

2. How often does your child have symptoms? (choose only one answer)
   ☐ Weekly ☐ Monthly ☐ Other

3. Has your child had any of the following tests done in the past? (choose all that apply)
   ☐ EEG ☐ MRI ☐CT ☐ Labs ☐ Genetic testing

4. What other specialists has your child seen in the past? choose all that apply)
   ☐ Another neurologist ☐ Geneticist ☐ Neurosurgeon ☐ Psychologist
   ☐ Psychiatrist ☐ Ophthalmologist ☐ Orthopedist ☐ Other

5. Has your child's condition/symptoms affected his/her developmental progress/school performance?
   ☐ Yes ☐ No

_____ _____ _____ _____
Parent/Guardian signature Reviewed by Date Time

For in-clinic use only

Temp	HR	RR	B/P	Wt (kg)	Ht (cm)	HC	O2 Sat

Pain Score	Pain Scale

Signature: _____ Date: _____ Time: _____