



1 Patient & Encounter Information

Name:	_____	Date of Visit:	_____
DOB / Age:	_____	Location of Service:	_____
Sex:	_____	Visit Type:	_____
MRN:	_____	Referring Provider:	_____
Primary Language:	_____	Pediatric Neurologist:	_____
Insurance / Payer:	_____	Accompanied by (parent / guardian):	_____

2 Chief Complaint

Primary neurological concern: \_\_\_\_\_

Duration: \_\_\_\_\_

3 History of Present Illness

GENERAL

Onset / duration / frequency / progression: \_\_\_\_\_

Context / triggers: \_\_\_\_\_

SYMPTOM CHARACTERIZATION

Seizures (type, triggers, duration, postictal state): \_\_\_\_\_

Abnormal movements (tremor, tics, chorea, dystonia): \_\_\_\_\_

Weakness / tone abnormalities: \_\_\_\_\_

Sensory changes: \_\_\_\_\_

Headaches / migraines: \_\_\_\_\_

Behavioral / cognitive concerns: \_\_\_\_\_

ASSOCIATED SYMPTOMS & IMPACT

Sleep / feeding / swallowing / coordination: \_\_\_\_\_

Functional impact (school, ADLs, play): \_\_\_\_\_

Caregiver input (regression, behavior, concerns): \_\_\_\_\_

PRIOR WORKUP & TREATMENTS

Prior workup (EEG, imaging, labs, genetic testing): \_\_\_\_\_

Prior treatments (meds, PT/OT, speech, behavioral, school): \_\_\_\_\_

4 Prenatal & Birth History

Maternal conditions / exposures:	_____	Birth weight / Apgar scores:	_____
Gestational age:	_____	Neonatal complications (NICU, seizures):	_____
Delivery type:	_____		

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## Developmental History

Gross motor: \_\_\_\_\_

Fine motor: \_\_\_\_\_

Speech / language: \_\_\_\_\_

Social / behavioral: \_\_\_\_\_

Regression: \_\_\_\_\_

School performance: \_\_\_\_\_

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## Past Medical & Surgical History

Neurological conditions: \_\_\_\_\_

Other chronic illnesses: \_\_\_\_\_

Surgeries (neuro / ortho): \_\_\_\_\_

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## Medications

Current medications: \_\_\_\_\_

Prior medications: \_\_\_\_\_

Adherence / side effects: \_\_\_\_\_

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## Allergies

Drug allergies + reaction: \_\_\_\_\_

Other relevant allergies: \_\_\_\_\_

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## Family History

Neurological / developmental / genetic / psychiatric disorders...

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## Social History

Household: \_\_\_\_\_

School / daycare: \_\_\_\_\_

IEP / 504 plan: \_\_\_\_\_

Activities / screen time: \_\_\_\_\_

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## Review of Systems (Focused)

Neurological: \_\_\_\_\_

Behavioral / Psych: \_\_\_\_\_

Sleep: \_\_\_\_\_

Other relevant systems: \_\_\_\_\_

## O Objective

### 12 VITALS & GROWTH

BP: \_\_\_\_\_ RR: \_\_\_\_\_ SpO<sub>2</sub>: \_\_\_\_\_  
HR: \_\_\_\_\_ Temp: \_\_\_\_\_ Height / Weight / HC: \_\_\_\_\_

### 13 NEUROLOGICAL EXAMINATION

Mental status: \_\_\_\_\_ Sensory: \_\_\_\_\_  
Cranial nerves: \_\_\_\_\_ Reflexes: \_\_\_\_\_  
Motor: \_\_\_\_\_ Coordination: \_\_\_\_\_  
Tone: \_\_\_\_\_ Gait: \_\_\_\_\_

### 14 DIAGNOSTIC DATA REVIEWED

MRI / CT: \_\_\_\_\_  
EEG: \_\_\_\_\_  
Labs / metabolic: \_\_\_\_\_  
Genetic testing: \_\_\_\_\_  
Independent interpretation performed: \_\_\_\_\_

## A Assessment

### 15 DIAGNOSES

Primary diagnosis: \_\_\_\_\_  
ICD-10 Code: \_\_\_\_\_  
Secondary diagnoses: \_\_\_\_\_  
Differential diagnoses: \_\_\_\_\_  
Severity / functional impact: \_\_\_\_\_

### 16 MEDICAL DECISION MAKING (MDM)

Problems Addressed: \_\_\_\_\_  
Data Reviewed: \_\_\_\_\_  
Risk Level (Low / Moderate / High): \_\_\_\_\_

## P Plan

### 17 MANAGEMENT

Medications: \_\_\_\_\_  
Therapies (PT / OT / Speech / Behavioral): \_\_\_\_\_  
Diagnostics ordered: \_\_\_\_\_  
Referrals: \_\_\_\_\_  
IEP / school coordination: \_\_\_\_\_

### 18 EDUCATION & SAFETY COUNSELING

Condition, prognosis, medication risks/benefits. Seizure precautions, fall risk, SUDEP discussion if applicable...

### 19 FOLLOW-UP

**Timeframe:** \_\_\_\_\_  
**Return precautions:** \_\_\_\_\_

**20 TIME / BILLING**

**Total time (minutes):** \_\_\_\_\_  
**Counseling time:** \_\_\_\_\_  
**Complexity:** \_\_\_\_\_

<b>Provider name &amp; credentials:</b> _____	<b>Date / Time:</b> _____
<b>Signature:</b> _____	<b>Facility:</b> _____
<b>NPI:</b> _____	<b>Visit type:</b> _____