SUZANNE GAZDA M.D.
INTEGRATIVE NEUROLOGY

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Patient Name: _____

Date of Birth: _____

Cell Phone: (_____)_____

Insurance Provider_____

Gender_____Height_____Weight_____

PANS/PANDAS CHILDRENS' INTAKE QUESTIONNAIRE

All of the information herein will be treated in accordance with all applicable confidentiality laws and practices and is intended solely for the use of Dr. Suzanne K. Gazda, MD.

Today's Date:_____/_____/_____

Your Cell Phone: (_____)_____

Emergency Contact Name:_____

Emergency Contact Phone: (_____)_____

Physician and Pharmacy Information

Primary Care Physician (Family Practice, Internist)

Name

Address

Phone

Fax

Email

Referring Physicians

Name

Address

Phone

Fax

Email

Other Physician/ Provider with Whom You Would Like Us to Communicate:

Name

Address

Phone

Fax

Email

Other Physician/ Provider with Whom You Would Like Us to Communicate:

Name

Address

Phone

Fax

Email

Preferred Retail Pharmacy

Name

Address

Phone

Fax

Mail Order/Alternate Pharmacy

Name

Address

Phone

Fax

Prior labs and Medical Records: Please send prior to visit.

Detailed history of the illness:

Was there a well-defined trigger?

What treatments have been tried?

What doctors have been seen?

And what were the results of all tests done?

What are the primary symptoms of concern now?

Have you done any reading on PANS or PANDAS?

Background info:

1. Gestational history

2. Birth medical history and past medical history including surgeries and dates of each.

List any hospitalizations

3 Vaccinations:
For kids: Provide vaccine history and do you follow the normal vaccine schedule?

If you are an adult, do you get the flu shot?

Have you had any recent vaccines that triggered any symptoms?

4. Developmental milestones: (for kids)

5. The names of your current doctors

6. Allergies

7. School

Current grade and history of school performance:

Where do you or did you go to school?

For adults: Give years you went to school and highest level of academic performance:

Social interactions at school with friends or peers etc:

8. Activities Outside of Work or School?

9. Infection/illness history

Recent or past history of infections:

Do you get sick often?

History of a tick bite past or recent?

Hw many times in the last year have your taken antibiotics?

10. Environment/home:
Has your home ever had water damage or mold?

Do you live near power lines?

Do you live near high air pollution ie near a road or factory?

Do you live on a farm or another environment where there are pesticides were being sprayed?

Do you or your child spend a lot of time in someone else's home or work?

11. Diet
Are you on a special diet?

What do you typically eat for breakfast, lunch or dinner?

12. Gut/stools
How often do you have a BM?

Are the stools well formed?

What gut symptoms due you have? Bloating, Pain, Nausea, etc?

13. Sleep:
What time is bedtime?

How long do you sleep?

What prevents you from sleeping well?

Do you take anything to help you sleep?

Do you have nightmares or vivid dreams? IF so how often?

Do you nap?

14. EMF
How much time are you online?

15. Skin health

16. Behavior/mood
Are you sad, depressed, moody, irritable, anxious, etc.?

17. Current Medications
Has your child or you started any new supplements or medications that we have not discussed?
If so, what Brand? Dosage? Timeline? Changes seen?

18. Fatigue
Do you complain of always feeling tired?

Does exercise make this better or worse or no change?

19. Family history of autoimmune disease or Immune Deficiency
Please list:

20. List all family members and their age that live in the household.

Is anyone in the family besides you, sick or ill often?

21. Any history of emotional trauma or abuse or PTSD?

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Have you experienced (or has your child experienced) a sudden onset of…
(YES or NO and rate on the scale)

Obsessions/Compulsions (OCD)?
Intrusive, recurrent thoughts (obsessions); excessive, repetitive rituals or behaviors (compulsions)
1= no symptoms
2= mild
3= moderate
4= severe
5= extreme *

Tics and what kind of tics?
Sudden repetitive motor movements or sounds
1= no symptoms
2= mild
3= moderate
4= severe
5= extreme *

Restricted Eating?
Restricted or reduced food intake
1 = no symptoms
2= mild
3= moderate
4= severe
5= extreme *

Anxiety?
Separation anxiety, fears, phobias
1= no symptoms
2= mild
3= moderate
4= severe
5= extreme *

Depression/Moodiness?
Sadness, irritability, sudden mood swings
1= no symptoms
2= mild
3= moderate
4= severe
5= extreme *

Aggression?
Rage, tantrums, aggressive behaviors
1= no symptoms ○
2= mild ○
3= moderate ○
4= severe ○
5= extreme * ○

Inattention or Hyperactivity?
Trouble paying attention, moving around a lot
1= no symptoms ○
2= mild ○
3= moderate ○
4= severe ○
5= extreme * ○

Worsening of Handwriting? And please provide examples.
Difficulty writing or drawing
1= no symptoms ○
2= mild ○
3= moderate ○
4= severe ○
5= extreme * ○

Sleep Disturbance?
Insomnia, frequent waking, night terrors
1= no symptoms ○
2= mild ○
3= moderate ○
4= severe ○
5= extreme * ○

Urinary Problems?
Frequent urination, daytime wetting, bed wetting
1= no symptoms ○
2= mild ○
3= moderate ○
4= severe ○
5= extreme * ○

Sensory Abnormalities?
Bothered by sounds, smells, textures, or lights
1= no symptoms ○
2= mild ○
3= moderate ○
4= severe ○
5= extreme * ○

Pain?
(i.e. muscles, joints , headaches, etc.)
Please describe what type of pain, what it feels like, how often, and what you do to help manage this.

Do you notice anything that causes the pain to get worse?

Additional screening evaluations may be required after initial assessments are reviewed.

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