Pediatric Rehabilitation Medicine
Follow-up

Medical History: Does your child have any **NEW** Medical Problems since your last visit? If so, please list:

Surgical History: Please list any surgeries your child has had since their last visit:

Family History: Please list any new information about the health of your family (child's siblings, parents, grandparents, aunts or uncles) members:

Social History

1) With whom does your child live (circle all that applies)?

   Mother Father Siblings Aunt Uncle Step-mother Step-father other: _____

2) Does anyone in your household Smoke? **Yes No**

3) Does your child attend (circle all that applies)?
   School (Name) _____ **Daycare Work None Other**: _____

   If in School: Grade _____ Ungraded Setting _____ Other: _____

4) Does your child have an ongoing Individualized Education Program (IEP)? **Yes No**

5) How many days of school or usual activity has your child missed in the last 2 months due to illness or other things (appointments, etc.) related to his /her condition? _____

6) What financial resources do you have for you/your child (Please Circle all that apply)?
   BCMH Medicaid waivers SSI DDS services other: _____

Therapy History

	School based	Outpatient	Home based	Other	How often?	None
Physical Therapy						
Occupational Therapy						
Speech Therapy						
Other:						

1) **Please circle any equipment that your child currently has:**

a) Braces: AFOs night stretching braces hand/wrist brace back/scoliosis brace

b) Mobility: crutches gait trainer manual wheelchair power wheelchair

Lift bath equipment walker stander bed/positioning equipment

c) **Augmentative device? No Yes:** _____

d) Other? _____

2) Does the patient take part in any activities and/or Hobbies (please describe)? **Yes No**

3) If applicable, does your child wear a bike helmet when riding a bike? **Yes No NA**

Current Problems

Please circle any **PROBLEMS** that your child currently has:

Over weight	**Underweight**	**Pain**	**Sleep**	
Itching	**Dry skin**	**Pressure sore**	**Skin Injury**	
Vision	**Hearing**			
Swallowing	**Drooling**	**Tracheostomy**		
Cough	**Wheezing**	**Shortness of breath**		
Poor circulation		**Swelling**		
Constipation	**Belly pain**	**Bowel incontinence**	**Reflux**	**G-tube**
Contractures	**Scoliosis**	**Bladder incontinence**		
Seizures	**Headache**	**Weakness**	**Poor mobility**	**Balance**
	Communication/language		**Hand/arm use**	**Sensation**
Blood clotting	**Early Puberty**	**Allergies**		

What questions do you have for us?

_____

_____

_____

_____

_____

Pediatric Rehabilitation Medicine
Cerebral Palsy Clinic

Dear Patient/Parent/Guardian,

Please complete each section of this questionnaire. Your answers will be examined by nurses and physicians before your clinic visit. All information will be kept confidential.

Date: ____/_____/_____

Patient's Name _____

Patient's Date of Birth ____/_____/_____ **Patient's Gender:** ☐ **Male** ☐ **Female**

	Mother	Father	Guardian
Home Phone			
Work Phone			
Cell Phone			
Email Address			

Address _____ Apt. _____

City _____ State _____ Zip code _____

Name of person completing this form: _____ _____

Please complete the form and mail, email or fax it to us ahead of time at GoCP@cchmc.org or 513-636-7360 (Attn: Sean Jameson) prior to your visit. You can also bring the form to your clinic visit (please hand to the nurse upon arrival).

Mailing Address:

Cincinnati Children's Hospital
Division of Physical Medicine and Rehabilitation
3333 Burnet Ave
Cincinnati, Ohio 45229-3039
Attn: Sean Jameson

Thank You!