Pediatric Rehabilitation Medicine New Visit

Medical History: Does your child have a history of (Please circle):

Seizures (epilepsy)	**Yes**	**No**	Hearing problems	**Yes**	**No**
Concussion	**Yes**	**No**	Vision problems	**Yes**	**No**
Traumatic brain injury	**Yes**	**No**	Gastroesophageal reflux	**Yes**	**No**
Stroke	**Yes**	**No**	Bladder dysfunction	**Yes**	**No**
Cerebral Palsy	**Yes**	**No**	Neurogenic bowl	**Yes**	**No**
Brain infection	**Yes**	**No**	Pressure sore	**Yes**	**No**
Anoxia (no oxygen to brain)	**Yes**	**No**	Osteoporosis (brittle bones)	**Yes**	**No**
Spina bifida (myelomeningocele)	**Yes**	**No**	Cancer	**Yes**	**No**
Spinal cord injury	**Yes**	**No**	Blood clotting issues	**Yes**	**No**
Muscle disorder	**Yes**	**No**	Metabolic disorder	**Yes**	**No**
Nerve disorder	**Yes**	**No**	Developmental delay	**Yes**	**No**

Surgical History: Please list any surgeries your child has had:

_____

_____

_____

Family History: Who in your family has had any of the following medical problems (check the appropriate box):

Medical Problem	**Yes**	**No**	**Relative(brother, aunt, mother, etc.) with that problem**	**Specific type of medical problem**
Birth defect				
Genetic Disorder				
Neurological or brain disease				
Stroke				
Other				

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!