

Comprehensive Neuromuscular Center Parent Intake Form Page 1 of 4

Patient Name:	DOB:	Gender:	Male	Female
Street Address: City: State: Home Phone:	Zip Code: Cell Phone:			
E-mail: Mother's Name:	Occupation:			
Father's Name:	Occupation:			
Has your child ever	been seen at Cincin	nati Children'	s Hospital	Medical Center? Yes No
Who referred you to	Cincinnati Children	n's (Name)		
Reason for Neurolo What concerns or qu		like addressed	when you	come to our clinic?
MEDICAL HIST Does your child have If yes, please explain	e any past or curren	t medical prol	olems?	☐ Yes ☐ No
Previous hospitalizat If yes, please explain Previous medication Any drug allergies: If yes, please explain	1: s: Yes No	Yes N	1 0	
Immunizations up to History of broken bo If yes, please explain	ones? Yes	No No		
PRENATAL/BIR Mother's age at patie Was your baby full t If no, how early? Describe any difficu	ent's birth: Facerm? Yes N weeks	Birth weight	: lbs	
Fetal movement:	Normal Dec	creased		
List medications take	en during pregnancy	y with your ch	nild:	





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PRENATAL/BIRTH Labor: Spontaneous Delivery: Vaginal Any difficulties during l If yes, please explain:	S	Indu	iced		in labor: Yes] No)		
BIRTH/NEONATAI	L HISTO	ORY:							
Apgar score (if known):	at	t one m	inute:	at five	e minutes:				
Did your baby require oxygen? Yes No									
If yes, please explain:									
Any special medical pro	blems as	a newb	orn?	Yes [] No				
If yes, please explain:									
Number of days in hosp	ital:								
FAMILY HISTORY	'• I ist me	mhers	of your c	hild's hirt	h family v	with	medic	al or neurological problem(s) (su	ch as
								s, childhood death, muscle/nerve	cii as
disorders, etc.)	<i>8</i> ,			, 8		, , ,		,	
Name	Relation	ship to	Patient	Living	Decease	ed	Age	Medical/Neurological Prol	olem
		•							
Are parents/grandparent	ts related	other th	nan by m	arriage? 🗌	Yes	No			
If yes, please explain:									
SOCIAL HISTORY	:								
Who else lives in the ho	me ⁹								
Name Relationship Age									
Tunic			Ren	attonship	115				
DEVELOPMENTAL	L HISTO	ORY:							
At what age did your ch			e activitie	es?					
Gross Motor							Language	Age	
Rolls over	rige	Reaches for objects			7.		Single words like "mama"	rige	
Sits alone	Pincer grip					Understands "wave bye-bye"			
Pulls to stand								2-3 word sentences	
Stands alone									
Walks alone									
Is your child: Right har	nded 🗌	Left ha	nded 🔲						
At what age level do yo				tioning?					

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EDUCATION	N HISTORY:	
Current grade:	School:	
Describe any sp	pecial help needed or specific problems noted in school:	
IEP/504 Plan	☐ Yes ☐ No	
IEP/504 Plan	∐ Yes ∐ No	

CURRENT & PAST MEDICAL HISTORY:

	None	Past	Present	Please describe
Weight Loss				
Weight Gain				
Headaches				
Sleep problems				
Visual changes				
Dizziness				
Fever				
Diarrhea or constipation				
Rash or skin problems				
Respiratory symptoms				
Nausea or vomiting				
Urinary difficulties				
Dark colored urine				
Joint or muscle pain				
Behavioral problems				
Learning problems				
Cardiac				
Spine				
Fractures				
Feet				
Hands				
Toe walking (at what age)				
Difficulty with walking				
Difficulty with running				
Difficulty getting up from floor				
Difficulty with jumping				
Muscle cramps/pains				
Hand tremors (at what age)				



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CURRENT MEDICATIONS: (Prescri	iptions, Pain Meds,	Over the Counter Meds,	Vitamins, Herbals)
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Drug	Dose/Amount	Frequency/Route	Brand Name	Reason for taking	How long if taking steroic
	send our report (I		e doctor and other l	nealth care providers):	Send to this
Name		Address		Phone	provider (check box)
Oo you have health	insurance?	s (if yes, complete inf	formation on next p	age) No	
Children's? Yes	☐ No	mpany to find out if the		child's medical expense	es at Cincinnati
·		. <u>-</u>	,		
arent/Guardian Sig	nature: Da	te:			

Growing Through Knowing

change the outcome

CENTER



COMPREHENSIVE NEUROMUSUCLAR CENTER

BEFORE WE CAN SCHEDULE AN APPOINTMENT, this form must be completed and the information listed on the checklist below must be received by us. Once we receive this information, a member of the center will contact you.

CHECKLIST OF MEDICAL INFORMATION TO BE SENT TO COMPREHENSIVE NEUROMUSCULAR

Copy of insurance cards (front and	back)								
From your primary care physician:									
 Growth charts* 									
 Relevant medical history* 	·								
 Immunization records* 									
If your child has been in the hospital	al:								
 All hospital discharge sum 	maries								
☐ Medical Reports for any of the follo	owing tests that your child may have ha	d:							
 Genetic (DNA) testing* 									
 Blood (CPK or CK) tests* 	- Blood (CPK or CK) tests*								
 Muscle biopsy* 									
 Reports of all prior special 	- Reports of all prior specialists evaluations*								
 Sleep, swallowing or feedi 	- Sleep, swallowing or feeding studies								
- Echocardiograms/EKG									
- MRI scans and X-rays									
- Electromyography (EMG) or nerve conduction studies									
- Neuropsychological Evaluation Report									
	Primary Insurance	Secondary Insurance							
Insurance Co. Name									
Policy ID#:									
roup #:									
ubscriber Name									
Subscriber SS #:									
Subscriber DOB:									
Subscriber Employer:									
nsurance Co. Phone #:									

If you have any questions filling out this form please call us for assistance.

After completing this form, please mail or fax to: Cincinnati Children's Hospital Medical Center Comprehensive Neuromuscular Center Attn: Care Manager

3333 Burnet Ave MLC #2015

Insurance Effective Date:

Cincinnati, OH 45229

Phone: (513) 803-3000 Fax: (513) 803-3300 E-mail: NeuromuscularCare@cchmc.org