Name: _____

MR#: _____ DOB: _____

Date: _____ Sex: _____

Name of person completing this form: _____

Cardiologist: _____ Pediatrician: _____

Please list any other physicians following your child: _____

_____

_____

_____

Parent(s)/Guardian(s): _____
Address: _____
Home phone: _____ Cell phone: _____ Work phone: _____

E-mail address: _____ Alternate e-mail: _____

MEDICATIONS:

Name of medication	How much do you give?	How often?

CHILD'S ETHNICITY:
Do you consider your child to be Latino or Hispanic? ☐ Yes ☐ No ☐ I don't know

CHILD'S RACE:
☐ American Indian/Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ More than One Race
☐ Unknown
☐ Other, please specify: _____

Does the child's parent/caregiver have physical limitations, visual or hearing deficits, learning difficulties or other special needs?
☐ Yes ☐ No If yes, please describe: _____

FAMILY INFORMATION:
Family Status- With whom child lives (Please check one):
☐ Both Parents ☐ Father Primarily ☐ Father + Other ☐ Neither Parent (Lives with Guardian)
☐ Mother Primarily ☐ Mother + Other ☐ Shared Care (Approx. 50%)

Who has legal custody of the child? _____

Is your child an adopted/foster child? ☐ Yes ☐ No
If yes, for how long and by whom? _____

_____

Name: _____

MR#: _____ DOB: _____

FAMILY INFORMATION continued:

Are parents married? ☐ Yes ☐ No If yes, when? _____
Are parents separated? ☐ Yes ☐ No If yes, when? _____
Are parents divorced? ☐ Yes ☐ No If yes, when? _____
Is a parent widowed? ☐ Yes ☐ No If yes, when? _____
Is/are there step-parent(s)? ☐ Yes ☐ No
If yes, when was the remarriage for either (or both) parents? _____

How many children less than or equal to age 18 (including patient) live in the household? _____

What is the ordinal (birth order) position of your child in the family? ☐ Oldest ☐ Middle or other ☐ Youngest ☐ Only child

SIBLINGS:

List all full, half, or step brothers and sisters of patient, living or dead, in order of birth. Add your own page, if needed.

Name	Age	Sex	Relationship	Highest Grade completed?	Living with patient?

Please provide name and relationship to the child/family of anyone else living in the home currently:

Name	Relationship

Major medical, emotional, or learning problems in family members:

_____

_____

INFORMATION ABOUT PARENT/GUARDIAN COMPLETING FORMS TODAY:

	Caregiver 1	**Caregiver 2**
Relationship to the Patient	☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Foster Parent ☐ Legal Guardian-related ☐ Legal Guardian-not related ☐ Other: _____	☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Foster Parent ☐ Legal Guardian-related ☐ Legal Guardian-not related ☐ Other: _____
Ethnicity	Are you Hispanic or Latino? ☐ Yes ☐ No ☐ I don't know	Are you Hispanic or Latino? ☐ Yes ☐ No ☐ I don't know
Race	☐ American Indian/Alaska Native ☐ Asian ☐ White ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ More than One Race ☐ Unknown/Not Reported ☐ Other; specify: _____	☐ American Indian/Alaska Native ☐ Asian ☐ White ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ More than One Race ☐ Unknown/Not Reported ☐ Other; specify: _____

Name: _____

MR#: _____ DOB: _____

	Caregiver 1 (continued)	Caregiver 2 (continued)
Education (Highest Level Completed)	☐ Kindergarten – 6 Grade ☐ 7th – 9th Grade ☐ 10th and/or 11th Grade ☐ High School Graduate (private, preparatory, parochial, trade, or public) ☐ Partial College of Trade School ☐ College Graduate ☐ Post Graduate Degree	☐ Kindergarten – 6 Grade ☐ 7th – 9th Grade ☐ 10th and/or 11th Grade ☐ High School Graduate (private, preparatory, parochial, trade, or public) ☐ Partial College of Trade School ☐ College Graduate ☐ Post Graduate Degree
Work History	Are you retired? ☐ Yes ☐ No Usual employment pattern? ☐ Full - time (at least 35 hrs/wk) ☐ Part – time (less than 35 hrs/wk) ☐ Contract work/variable hrs ☐ Currently full – time homemaker ☐ Unable to work due to injury/disability ☐ Currently unemployed ☐ Student Occupation: _____ _____ _____	Are you retired? ☐ Yes ☐ No Usual employment pattern? ☐ Full - time (at least 35 hrs/wk) ☐ Part – time (less than 35 hrs/wk) ☐ Contract work/variable hrs ☐ Currently full – time homemaker ☐ Unable to work due to injury/disability ☐ Currently unemployed ☐ Student Occupation: _____ _____ _____

HOUSEHOLD INCOME:

Combined Household Yearly Income (Please check one):

☐ Less than $25,000 ☐ $26,000-$50,000 ☐ $51,000-$75,000
☐ $76,000-$100,000 ☐ $101,000-$150,000 ☐ Greater than $150,000

STRENGTHS AND ASSETS OF THE CHILD AND FAMILY:

What are your child's strengths? _____

_____

What are your family's strengths? _____

_____

Do you currently have any concerns with the following?:

☐ Transportation ☐ Providing for your family
☐ Insurance coverage ☐ Employment
☐ Finances

How would you describe the level of stress in your family?

☐ Unbearable
☐ High
☐ Average
☐ Low

What concerns you most about your child currently? _____

_____

_____

Name: _____

MR#: _____ DOB: _____

Are you currently working with any other community agencies?

	Early intervention services		Legal services
	Caseworker with a state or county agency		Mental health provider
	Other:		

Are you aware of programs to assist you with managing your child's diagnosis (Ex. BCMH, Help Me Grow, CCHMC support groups)?
☐ Yes ☐ No

Would you like to speak to one of our Family Financial Advocates to assist you with finding help with your medical bills?
☐ Yes ☐ No

Who do you rely on when you need help or support for your child? _____

Would they be willing to also attend appointments? _____

YOUR CHILD'S HISTORY:

Was your child premature at birth? (less than 37 weeks gestation) ☐ Yes ☐ No
Was your child a multiple gestation (a twin or triplet)? ☐ Yes ☐ No

At what age was your child diagnosed with heart disease?
☐ Prenatal
☐ Pre-discharge from the newborn nursery
☐ Post-discharge to 29 days of life
☐ 30 days of life to 1 year
☐ More than 1 year of life, specify age: _____ years

How many times has your child been to the hospital for an overnight stay during his/her life?

Cardiac Related:				Other:			
	0 times		6-10 times		0 times		6-10 times
	1 time		11-20 times		1 time		11-20 times
	2-5 times		More than 20 times		2-5 times		More than 20 times

Date of last hospitalization? _____

How many times has your child been to the hospital for a cardiac catheterization or interventional procedure? _____
Date and type of last procedure (cardiac cath, other procedure): _____

How many times has your child been to the hospital for cardiac surgery? _____
Date of last cardiac surgery: _____

How many visits to the doctor (any doctor) has your child had in the past 12 months? _____

Has your child ever required CPR? ☐ Yes ☐ No

Has your child ever been hospitalized for more than 2 weeks at one time? ☐ Yes ☐ No

Has your child ever been diagnosed with a genetic abnormality or syndrome? ☐ Yes ☐ No
If yes, please describe: _____

Was your child ever on ECMO (life support)? ☐ Yes ☐ No

Name: _____

MR#: _____ DOB: _____

BEHAVIORAL AND EMOTIONAL DEVELOPMENT:

Check the box that best describes your child's behavior.

Behaviors:	Always	Frequently	Occasionally	Seldom	Never
Has difficulty paying attention					
Has trouble sitting still so much that it interferes with daily routines (i.e., is in constant motion, fidgets)					
Has trouble with completion of tasks					
Has temper tantrums					
Acts aggressive or has angry behaviors					
Has difficulty following rules and routines					
Avoids eye contact					
Reacts emotionally or aggressively to touch					
Sensitive to loud noises (i.e., sirens, barking dogs)					
Has trouble getting along with other children					
Hurting themselves on purpose					
Picky eater, especially regarding food textures					

Have you been concerned that your child's development has been delayed? ☐ Yes ☐ No

If yes, when did you first become concerned about your child's development? _____

What area of development concerned you (i.e., talking, eating, walking, etc.)? _____

How old do you think your child acts? _____

Did your child meet the following milestones at appropriate ages?

Milestones:	Yes	No	Unknown	N/A
Sat alone				
Walked without help				
Said "mama" or "dada" with meaning				
Able to say 5-10 words				
Able to combine 2 words together				
Potty-training				
Dressing themselves				

Please describe any milestones that were not met at appropriate ages: _____

_____

_____

MENTAL HEALTH HISTORY:

Does your child have any mental health, behavior, or learning problems? ☐ Yes ☐ No

If yes, please describe: _____

Has your child ever had treatment for any of the above problem(s)? ☐ Yes ☐ No

If yes, what treatment? _____

Where? _____ When? _____

Is your child currently receiving any of the following services? If yes, where and how often?

Services:	Yes	No	Location	How often
Physical therapy				
Occupational therapy				
Speech / language therapy				
Behavioral counseling				
Early intervention (Help Me Grow, First Steps)				

Other (please explain): _____

_____

Name: _____

MR#: _____ DOB: _____

NUTRITION HISTORY:

Are you concerned about your child's nutrition or weight status? ☐ Yes ☐ No

Why? _____

Has your child had any recent change in weight that concerns you? ☐ Yes ☐ No

If so, how much and over what length of time? _____

Is your child on a special diet or modified diet? ☐ Yes ☐ No

If yes, what type of diet? ☐ Low fat ☐ Diabetic ☐ Pureed ☐ Thickened liquids ☐ Tube feedings ☐ Other: _____

Does your child take any supplements to help them maintain or gain weight (i.e., Pediasure, Boost, Ensure)? ☐ Yes ☐ No

If yes, what kind and how much? _____

Would you like to speak with a registered dietician during your clinic visit? ☐ Yes ☐ No

NEUROLOGIC HISTORY:

Has your child or anyone in your family ever had any of the following (check all that apply and describe in the space below, including diagnosis, any testing done, and treatment including therapy or medications):

	Your child	Family	Comments
Seizures			
Epilepsy			
Staring spells			
Headaches			
Migraines or other types of headaches			
Repetitive movements (tics, twitches, Tourette Syndrome or Tic Disorder)			
Tremors			
Other movement issues			
Weakness on one side of the body			
Paralysis			
Stroke/brain injury (please indicate if your child is on blood thinner medications)			

Additional comments: _____

_____

Has your child had any neurological medical testing? (check all that apply):

☐ EEG (brain wave test) ☐ MRI ☐ CT

If so, please list dates: _____

Any other testing for neurological conditions that we should know about? _____

_____

Signature of Person Completing the Form Printed Name Date Time

_____

Relationship to Patient

AFTER COMPLETING FORMS, PLEASE EMAIL, FAX, OR MAIL TO:

Mailing Address:
CCHMC, MLC 2003
ATTN: Neurodevelopmental Clinic Care Team
3333 Burnet Ave
Cincinnati, Ohio 45229

E-mail: ndc@cchmc.org

Fax: 513-636-9276

Call Sarah Seibert 513-803-5026 with any questions