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?

Please answer the following questions if your child is currently taking or has previously taken medications to treat behavior difficulties or Attention Deficit Hyperactivity Disorder (ADHD):

When did they start (and stop if applicable) taking the behavior or ADHD medicine? ____________________________

Has the medication type or dosage ever changed? ☐ Yes ☐ No ☐ I don't know
Please describe: ____

Does the medication help your child's behavior difficulties or ADHD symptoms? ☐ Yes ☐ No ☐ I don't know
Please describe: ____

Does your child have side effects from the medication? ☐ Yes ☐ No ☐ I don't know
Please describe: ____

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: ____

CHILD'S RACE continued:

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? ____

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 either 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:

____
____
____
____

Name: ______________________________

MR#: ________________ DOB: ________

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:______________________
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? ____

____

____

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? ________________________________

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

YOUR CHILD'S HISTORY continued:

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

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, how old was your child when you first became concerned about 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 problems? ☐ Yes ☐ No

If yes, what treatment? ____

Where? ____When? __________________________________

MENTAL HEALTH HISTORY continued:

Is your child currently receiving any of the following services? If so, 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): ____

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: ____

NEUROLOGIC HISTORY continued:

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

EDUCATIONAL HISTORY:
Name of child's school: ______________________________
School district in which you live: ______________________________
School contact person: ______________________________

Attended pre-school? ☐ Yes ☐ No
Attended kindergarten? ☐ Yes ☐ No
In special education classes? ☐ Yes ☐ No

Current grade level in school: ________________________ Typical report card grades? ____________________

Repeated grade level(s)? ☐ Yes ☐ No Grade level(s) repeated? ______________________

Has your child ever had psychological testing at school? ☐ Yes ☐ No
If so, please attach a copy of the report or have a copy sent to us.

Has your child ever been suspended/expelled? ☐ Yes ☐ No

If yes, what grade level(s)? __________________________________ Why? ____________________________________

Where did your child attend school for the following grades (please list the district as well)? Please list below any moves that were made in your child's educational career.
Pre-K ______________________________
Kindergarten ______________________________
Elementary ______________________________
Middle/Jr. High ______________________________
High School ______________________________

Does your child have any of the following services at school?

	Individualized Education Plan (IEP)		One on one assistance in reading, math, etc.
	504 Plan		Response to Intervention (RTI)
	Behavior Plan		Other, please describe: ____________________
	Specialized Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy, etc.)		____ ____
	I am not sure if my child is receiving extra services at school		

Is your child currently experiencing and/or have they experienced difficulty in the past with any of the following tasks? Please mark all that apply.

Tasks:	Currently	Past
Catching/throwing a ball		
Understanding spoken information		
Speaking so he or she is understood		
Providing personal information (i.e., age, number of siblings)		
Using utensils, crayons, pencils, scissors		
Telling stories		
Motor skills (walking, running, hopping, skipping, etc.)		

Is your child experiencing difficulty with the following learning related tasks? Please mark all that apply.
☐ Counting skills ☐ Identifying colors ☐ Identifying shapes

Does your child socialize with same age children?

	Yes	No		Yes	No
At school?			In the neighborhood?		
With family friends?			With siblings and/or other cousins?		

Please list any concerns related to school: ______________________________

Approximately how many hours per day does the child watch television? ________________ Play video games? _____

Name: ______________________________

MR#: ________________ DOB: ________

My child participates in the following activities:

Activity:	Yes	No	How often?
Community sports			
Gym			
Community activities (clubs, scouts, etc.)			
Active play/backyard sports			
Other			

Are there any physical restrictions or adaptations used during the above items? _________________________________

____

Signature of Person Completing the Form | Printed Name | Date | Time

____

Relationship to Patient

<u>AFTER COMPLETING FORMS, PLEASE EMAIL, FAX, OR MAIL TO:</u>

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

<u>Email:</u> ndc@cchmc.org

<u>Fax:</u> 513-636-9276

Call Sarah Seibert 513-803-5026 with any questions