Name: _____

MR#: _____ DOB: _____

Date: _____ Sex: _____

Name of person completing this form: _____ Relationship to patient: _____

Cardiologist: _____ Pediatrician: _____

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: _____

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: _____

Name:_____

MR#: _____ DOB: _____

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 your/your child's ordinal (birth order) position 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

	Caregiver1 (continued)	Caregiver 2 (continued)
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? _____

_____

Name: _____

MR#: _____ DOB: _____

Do you currently have any concerns with the following?
☐ Transportation
☐ Insurance coverage
☐ Providing for your family
☐ 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 ☐ Post-discharge to 29 days of life
☐ Pre-discharge from the newborn nursery ☐ 30 days of life to 1 year ☐ More than 1 year of life, specify age: ____

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

Name: _____

MR#: _____ DOB: _____

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

Does your child get tired easily when they are active? ☐ Yes ☐ No
If so, does it affect their ability to carry out their day? ☐ Yes ☐ No
Does it affect their relationships with friends (don't feel "normal" because they can't keep up)? ☐ Yes ☐ No
Do you have any questions about kinds of exercise are good or safe for your child? ☐ Yes ☐ No

Have any of your child's doctors told you to limit their activity in any way? ☐ Yes ☐ No
If yes, how? _____

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 meeting the following milestones at appropriate ages?

Milestones:	My child met this milestone at an appropriate age	My child DID NOT meet this milestone at an appropriate age
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: _____

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? _____

Name: _____

MR#: _____ DOB: _____

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 ☐ 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:

Have you/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? _____

If you are bringing in your teenager (12 years and older), are you aware of your teen's use of the following:

	Yes	No	Unsure
Tobacco			
Alcohol			
Drugs			

Name: _____

MR#: _____ DOB: _____

EDUCATIONAL HISTORY:

Name of your/your child's school: _____

School district in which you live: _____

School contact person: _____

Phone number: _____ Email address: _____

Attended pre-school? ☐ Yes ☐ No
Attended kindergarten? ☐ Yes ☐ No
In special education classes? ☐ Yes ☐ No If yes, type of services? _____
When? _____

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

Have you/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.

Have you/your child ever been suspended/expelled? ☐ Yes ☐ No

If yes, what grade level(s)? _____ Why? _____

Current grade level in school: _____

What grades do you/your child typically earn in the following subjects?

Reading		Music		Science		Spelling	
Math		Social Studies		Physical Education		Art	

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 _____

Do you/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		_____

Name:_____

MR#: _____ DOB: _____

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

Tasks:	Currently	Past
Confusing left from right		
Using utensils, crayons, pencils, scissors		
Understanding spoken information		
Labeling and describing items		
Able to keep up the pace of his/her peers in school		
Motor skills (walking, running, hopping, skipping, etc.)		
Telling stories		
Speaking so he or she is understood		
Providing personal info (i.e., address, phone number, birth date)		
Reading sight words		
Reading at an appropriate pace		
Spelling individual words		
Counting skills		
Writing legibly		
Solving word problems		
Computer skills appropriate for age		
Understanding that each letter has an individual sound		
Understanding what is read in a sentence and a paragraph		
Spelling within a paragraph		
Using a writing instrument (i.e., pen, pencil)		
Writing an accurate sentence and a logical paragraph		
Basic calculation skills (adding, subtracting, multiplication, division)		
Multi-digit calculation skills (calculations containing more than one step)		
Memory		
Attention		
Organization		
Completion of tasks		
Taking responsibility for one's actions		
Completion of homework		
Establishing relationships		

If so, please describe: _____

_____

_____

_____

Who do you/your child prefer to socialize with:

	Younger children	Same age	Older children
At school?			
In the neighborhood?			
With family friends?			
With siblings and/or cousins?			

Please list any other strengths/weaknesses/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			

Did your child need any help or special equipment completing the above activities? ☐ Yes ☐ No
If yes, explain:_____

_____

_____

_____

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

Email: ndc@cchmc.org

Fax: 513-636-9276

Call Sarah Seibert 513-803-5026 with any questions