Name: _____

MRN: _____ DOB: _____

Date: _____

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 you child is currently taking or has previously taken medications to treat Attention Deficit Hyperactivity Disorder (ADHD):
When did they start (and stop if applicable) taking the 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 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_____

FAMILY INFORMATION:
Have there been any changes in your family status since the last time you attended Neurodevelopmental Clinic (i.e. whom the child lives with, legal custody, marriage, separated, divorce, widowed)? ☐ Yes ☐ No
If yes, please explain: _____

_____

_____

If no changes, skip to YOUR CHILD'S HISTORY (page 4).

Name: _____

MRN: _____ DOB: _____

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:

	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 ☐ 7^{th} – 9^{th} Grade ☐ 10^{th} and/or 11^{th} Grade ☐ High School Graduate (private, preparatory, parochial, trade, or public) ☐ Partial College of Trade School ☐ College Graduate ☐ Post Graduate Degree	☐ Kindergarten – 6 Grade ☐ 7^{th} – 9^{th} Grade ☐ 10^{th} and/or 11^{th} Grade ☐ High School Graduate (private, preparatory, parochial, trade, or public) ☐ Partial College of Trade School ☐ College Graduate ☐ Post Graduate Degree

Name: _____

MRN: _____ DOB: _____

	Caregiver 1 (continued)	Caregiver 2 (continued)
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

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:		

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? _____

Name: _____

MRN: _____ DOB: _____

YOUR CHILD'S HISTORY:

Has your child been hospitalized or had any major procedures since your last visit to the Neurodevelopmental Clinic?
☐ Yes ☐ No
If yes, please describe: _____

If there have been no changes since the last visit, you may skip to the end of the form.

How many visits to the doctor (any doctor) has your child had in the past 6-12 months? _____

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

How old do you think your child currently 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? _____

Name: _____

MRN: _____ 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:

Do you have any new nutritional or weight concerns since your last visit to the Neurodevelopmental Clinic? ☐ Yes ☐ No

If yes, please describe_____

Would you like to speak with e Registered Dietician at your follow-up NDC 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 testing since your last visit to the Neurodevelopmental Clinic? (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? _____

EDUCATIONAL HISTORY:

Name of child's school: _____

School district in which you live: _____

School contact person: _____

Phone Number: _____ Email Address: _____

Current grade level in school: _____ Typical report card grades: _____

Attended pre-school? ☐ Yes ☐ No

Attended kindergarten? ☐ Yes ☐ No

In special education classes? ☐ Yes ☐ No

Name: _____

MRN: _____ DOB: _____

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: _____

MRN: _____ 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, please explain: _____

Has your child experienced any positive outcomes because of the NDC's recommendations or support? ☐ Yes ☐ No
If yes, please explain:

Since your last visit, is your child receiving any extra services because of the NDC team? ☐ Yes ☐ No
If yes, please 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