

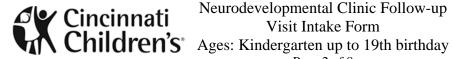
The Heart Institute Neurodevelopmental Clinic Follow-up Visit Intake Form Ages: Kindergarten up to 19th birthday Page 1 of 8

Name:	
MRN:	
DOB:	

Date:		•				
	rm: Relationship to patient:					
Cardiologist:	rician:					
Any other physicians following your						
Parent(s)/Guardian(s):						
Address:						
		Work phone:				
E-mail address:	Altern	nate e-mail:				
MEDICATIONS:						
Name of medication	How much do you give?	How often?				
Please answer the following questions difficulties or Attention Deficit Hyper When did they start (and stop if applic	ractivity Disorder (ADHD):	s previously taken medications to treat behavior medicine?				
Has the medication type or dosage ever Please describe:						
Please describe:		otoms?				
Does your child have side effects from Please describe	n the medication? Yes No] I don't know				
FAMILY INFORMATION:						
	ge, separated, divorce, widowed)?	ttended Neurodevelopmental Clinic (i.e. whom the Yes No				

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





The Heart Institute Neurodevelopmental Clinic Follow-up

Page 2 of 8

Name:	
MRN:	
DOB: _	

SIBLINGS:

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

List all full, half, or step brothers a	na siste	ers of p	atient, iiving or dead, ii	i order of birth. Add your own p	age, ir needed.
Name	Age	Sex	Relationship	Highest Grade completed?	Living with patient?
					•
_		1			
Please provide name and relationsh	ip to th	e child	/family of anyone else	living in the home currently:	_
Name			Relationship		
					1
					J
Major medical, emotional, or learn	ing pro	blems i	in family members:		
,			,		

INFORMATION ABOUT PARENT/GUARDIAN:

	Caregiver 1:	Caregiver 2:
Relationship to	Mother Father Grandmother	Mother Father Grandmother
the Patient	Grandfather Foster Parent	Grandfather Foster Parent
	Legal Guardian-related	Legal Guardian-related
	Legal Guardian-not related	Legal Guardian-not related
	Other:	Other:
Ethnicity	Are you Hispanic or Latino?	Are you Hispanic or Latino?
v	☐ Yes ☐ No	☐ Yes ☐ No
	I don't know	I don't know
Race	American Indian/Alaska Native	American Indian/Alaska Native
	Asian	Asian
	White	White
	Black or African American	Black or African American
	Native Hawaiian or Other Pacific Islander	Native Hawaiian or Other Pacific Islander
	More than One Race	More than One Race
	Unknown/Not Reported	Unknown/Not Reported
	Other; specify:	Other; specify:
Education	☐ Kindergarten – 6 Grade	☐ Kindergarten – 6 Grade
(Highest Level	$\prod 7^{th} - 9^{th}$ Grade	$\prod 7^{th} - 9^{th}$ Grade
Completed)	10 th and/or 11 th Grade	10 th and/or 11 th Grade
	☐ High School Graduate (private, preparatory,	☐ High School Graduate (private, preparatory,
	parochial, trade, or public)	parochial, trade, or public)
	Partial College of Trade School	Partial College of Trade School
	College Graduate	College Graduate
	Post Graduate Degree	Post Graduate Degree



The Heart Institute Cincinnati Children's Neurodevelopmental Child I Share I Shar

Name:	
MRN:	
DOB:	

-	1 uge 3 01 0							
	Caregiver 1 (continued)	Caregiver 2 (continued)						
Work History	Are you retired?	Are you retired?						
•	Yes No	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:	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 far	mily's strengths?							
Trans	have any concerns with the following? portation Providing for your family oyment Insurance coverage ces							
☐ Unbe ☐ High	Average							
Are you currently	working with any other community agencies?							
	vention services Legal se	rvices						
		nealth provider						
Other:	, , , , , , , , , , , , , , , , , , ,	<u> </u>						
Are you aware of programs to assist you with managing your child's diagnosis (Ex. BCMH, Help Me Grow, CCHMC support groups)? Yes No								
Yes	No	to assist you with finding help with your medical bills?						
Who do you rely	on when you need help or support for your child?							



The Heart Institute Neurodevelopmental Clinic Follow-up Visit Intake Form

Name:	
MRN:	
DOB:	

Children's Ages:	DOB	:					
YOUR CHILD'S HISTORY: Has your child been hospitalized or had a yes No If yes, please describe:	any major proced	dures since	your last v	visit to the Neu	ırodevelopmenta	ıl Clinic?	
If there have been no changes since the l	ast visit, vou ma	v skip to th	e end of the	ne form.			
How many visits to the doctor (any doctor							
Does your child get tired easily when the If so, does it affect their ability to ca Does it affect their relationships with Do you have any questions about kin Have any of your child's doctors told you	rry out their day n friends (don't f nds of exercise a ou to limit their a	? Yes Yes Feel "normate good or sectivity in an	l" because safe for yo ny way? [ur child? 🗌 Y		□ No	
If yes, how? BEHAVIORAL AND EMOTIONAL I Check the box that best describes your cl	DEVELOPMEN			ı			
Behaviors:			Always	Frequently	Occasionally	Seldom	Never
Has difficulty paying attention					Ž		
Has trouble sitting still so much that it i	nterferes with da	aily					
routines (i.e., is in constant motion, fidg	gets)						
Has trouble with completion of tasks							
Has temper tantrums							
Acts aggressive or has angry behaviors							
Has difficulty following rules and routi	nes						
Avoids eye contact							
Reacts emotionally or aggressively to to	ouch						
Sensitive to loud noises (i.e., sirens, bar	king dogs)						
Has trouble getting along with other ch	ildren						
Hurting themselves on purpose							
Picky eater, especially regarding food to	extures						
Have you been concerned that your child If yes, how old was your child when you What area of development conce How old do you think your child acts?	i first became co erned you (i.e. ta	oncerned ab alking, eatin	out develo g, walking	pment?			
· · ·			•				
Did your child meet the following milest				I I1	NT/A	1	
Milestones:	Yes	No		Unknown	N/A		
Sat alone Welked without help						-	
Walked without help Said "mama" or "dada" with meaning		+				1	
						-	
Able to say 5-10 words Able to combine 2 words together		1				1	
		+				1	
Potty-training Dressing themselves		+				1	
		1				J	
Please describe any milestones that were	not met at appro	opriate ages	:				



The Heart Institute Neurodevelopmental Clinic Follow-up Visit Intake Form

MRN:			
DOB:			

Name: _____

Children's Ages: Kinderg	arten u Page 5 o	p to 19 of 8	9th birthd	ay	DOB:	
Does your child have any mental health, behavior If yes, please describe:	, or lear	ning pr	oblems?	☐ Ye	s 🗌 No	
Has your child ever had treatment for any of the a If yes, what treatment?						
Where?			When?			
Is your child currently receiving any of the follow	ing serv	rices? It	f so, where	and hov	v often?	
Services:	Yes	No			cation	How often?
Physical therapy						
Occupational therapy						
Speech / language therapy						
Behavioral counseling						
Early intervention (Help Me Grow, First Steps)						
Other (please explain):	· ·					
1 ,						
NUTRITION HISTORY:						
Do you have any new nutritional or weight concer	rns since	e your l	ast visit to	the Neur	rodevelopmental Cli	inic? Yes No
If yes, please describe:						
	, ,	C 11	NIDO	7		
Would you like to speak with e Registered Dietici	ian at yo	ur Ione	w-up NDC	Visit?	∐ Yes [N0
NEUROLOGIC HISTORY:						
Have you/your child or anyone in your family eve	er had ar	v of th	e following	check	all that apply and de	escribe in the space
pelow, including diagnosis, any testing done, and						
	Your		Family	Comm	·	
Seizures	1001		1 uning	0011111		
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:						
0 1911 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0 / 1	1 11	1 4 1)			
Has your child had any neurological medical testi		eck all t	nat appiy):			
EEG (brain wave test) MRI CT						
If so, please list dates:						
Any other testing for neurological conditions that	we shou	ıld kno	w about?			
					.,	·
If you are bringing in your teenager (12 years and	oider),	are you	aware of y	your teer	s use of the follow	ing:
Yes No Unsure						
Tobacco						
Alcohol						
Druge						

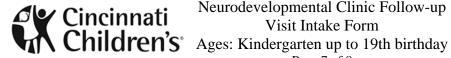
	168	110	Ullsule
Tobacco			
Alcohol			
Drugs			



The Heart Institute Neurodevelopmental Clinic Follow-up Visit Intake Form Kindergarten up to 19th birthday

Name:	
MRN:	
DOB:	

4111	ZIIIIUIEIIS Age	es: Kindergarten Page (DOB:		
	ONAL HISTORY: our/your child's school:					
School dist	rict in which you live:					
	tact person:					
	nber:					
Attended k In special e	indergarten?	Whe	en?			
Have you/y	rade level(s)? Yes Yes I Your child ever had psychouse attach a copy of the re	logical testing at so				
If yes, wha	your child ever been suspert grade level(s)? de level in school:	•	Why?			
What grade	es do you/your child typica	lly earn in the foll	owing subjects?			
Reading	Music		Science		Spelling	
Math	Social Stu	dies	Physical Education		Art	
were made Pre-K Kindergart Elementary Middle/Jr.	your child attend school for in your child's educationa en High	l career.				
Do vou/voi	ar child have any of the fol	lowing services at	school?			
	idualized Education Plan (ne on one assistance	e in reading, mat	h, etc.
504 F	,	•		Response to Intervention (RTI)		
Beha	vior Plan			ther, please describe		
-	alized Services (Occupation and Language Therapy,	10.0		· •		
Lam	not sure if my child is rece	ivino extra service	s at school			



The Heart Institute Neurodevelopmental Clinic Follow-up

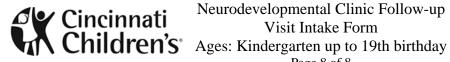
Page 7 of 8

Name:	
MRN:	
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		

Organization						
Completion of tasks						
Taking responsibility for one's ac	tions				_	
Completion of homework						
Establishing relationships						
f so, please describe:						
EDUCATIONAL HISTORY con Who do you/your child prefer to so		Same age	Older childre	n		
At school?	1 ounger emilieren	zume uge				
In the neighborhood?						
With family friends?						
With siblings and/or cousins?						
Please list any other strengths/weak	enesses/concerns rela	ated to schoo	l:			
Approximately how many hours pe	er day does the child	watch televis	sion?	Play vi	deo gam	es?



The Heart Institute Neurodevelopmental Clinic Follow-up

Page 8 of 8

Name:	
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DOB:	
DOB	

	1 450 0 01 0	,			
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 If yes, please explain:			pove activities? Ye	es No	
Has your child experienced any positive outcomes If yes, please explain:	s because o	of the NI	OC's recommendations	or support? Yes	No
Since your last visit, is your child receiving any ex If yes, please explain:	xtra service	es becau	se of the NDC team?	Yes No	
Signature of Person Completing the Form			Printed Name	Date	Time

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

Mailing Address: Email: ndc@cchmc.org Fax: 513-636-9276

CCHMC, MLC 2003

Relationship to Patient

ATTN: Neurodevelopmental Clinic Care Team

3333 Burnet Ave

Cincinnati, Ohio 45229

Call Sarah Seibert 513-803-5026 with any questions