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

Name: ______________________

MRN: ______________________

DOB: ______________________

Date: ______________________

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 you 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______________________

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).

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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 ☐ 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

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	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
☐ Employment ☐ Insurance coverage
☐ 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:		

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? ____________________________

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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? ____________________

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 youi 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: ____________________

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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? ______________________

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:
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			

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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		

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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: ____

____

____

EDUCATIONAL HISTORY continued:

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? ____________

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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

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

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