1 CP Place PLLC
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New Patient Form

Dear Parent:

Thank you for your interest in 1 CP Place, a clinic like no other. We offer a very comprehensive evaluation of our patients. In order to make your visit as productive and timely as possible, it is very important that you fill out this form to the best of your ability *as soon as possible*. Once you return the completed form to us, we can schedule an appointment. Please call us if you have any questions. We look forward to your visit!

Reason for your visit:	

Patient name		Date of Birth	

Mother's name		Father's name	
Address		Address (if different)	
Home Phone		Home Phone	
Cell Phone		Cell Phone	
Email		Email	

Primary Care Provider		Phone	

Referring Physician		Phone	

Please note that depending on your coverage, your insurance may require a formal referral from your primary physician. Please contact your insurance for information.

Chief concerns:
Please rank your top **THREE** concerns in order of priority, with "1" being your greatest concern.

	Accessibility		Nutrition/Feeding/Reflux		Spasticity/Tone Issues
	Arm and Hand Function		Orthopedic Issues		Sports
	Communication		Pain		Therapy
	Daily Living Activities		School		Vision Issues
	Equipment/Braces		Seizures		Walking
	Fine Motor Skills		Sleep		Other:

Name: _____ DOB: _____

CP Diagnosis:

1) Has your child been given a formal diagnosis of cerebral palsy? Yes ____ No ____

If yes, what type of cerebral palsy was diagnosed?

	Ataxic		Athetoid		Dystonic
	Spastic Hemiplegic		Spastic Diplegia		Spastic Quadriplegia
	Hypotonic		Mixed		Don't Know
	Other:				

Which side is involved?

	Right		Left		Both

Mobility:

Orthotics (braces)? Yes ____ No ____

If yes, type of orthotics: _____

Walking:

	Independent – no device		Independent – with device
	Dependent – requires human assistance		

Assistive Device (select all that apply):

	No Assistive Device		Canes		Crutches
	Walker		Gait Trainer		

Stairs Up/Ascend:

	Independent – no railing		Independent – uses railing
	Dependent – requires human help to climb		Unable to climb stairs

Stairs Down/Descend:

	Independent – no railing		Independent – uses railing
	Dependent – requires human help to climb		Unable to climb stairs

Wheelchair? Yes ____ No ____

If yes, operates independently? Yes ____ No ____

Manual _____ Power _____

Transfers:

	Independently		With Human Assistance		Dependent – Full lift
	Does seated transfer		Does stand and pivot transfer		

Name: _____ DOB: _____

2) Does your child have intellectual disability/cognitive problems? Yes ____ No ____

What age or grade level do you think your child functions at? _____

3) Does your child have difficulty speaking/communicating? Yes ____ No ____

If yes select all that apply:

	No words		Single words only
	2 word sentences		3-4 word sentences
	Full sentences		Difficult to understand
	Signs – Uses Yes/No signs		Signs – Uses Yes/No switches
	Uses Computerized Communication Device. Name of device:		

4) Has your child been diagnosed with epilepsy? Yes ____ No ____

If yes, type of epilepsy: _____

Date of first seizure: _____

Date of most recent seizure: _____

What medications has your child been on for seizure (list all tried):

5) Has you child been diagnosed with any behavior problems (select all that apply):

	Autism		ADHD		Attention Difficulty (w/o hyperactivity)
	Anxiety		Depression		Obsessive Compulsive Disorder
	Other:				

Name: _____ DOB: _____

Treatments for CP/Tone:
Has your child had any of the following treatments for their motor disorder?

Medication	Oral ✓	G-tube ✓	Date Med Started	Stop Date or Current Dose
Baclofen				
Diazepam (Valium)				
Sinemet (carbidopa/levodopa)				
Gabapentin (Neurontin)				
Trihexyphenidyl (Artane)				
Clonidine				
Tizanidine				
Dantrolene (Dantrium)				
Other:				

Has your child had Botulinum Toxin Injections? Yes ____ No ____

If yes (circle one): Botox or Myobloc

Date of first injections	
Date of most recent injections	
Which muscles?	

Phenol Injections? Yes ____ No ____

Date of injections	
Location	

Alcohol Injections? Yes ____ No ____

Date of injections	
Location	

Serial Casting? Yes ____ No ____

Date of first round of casting	
Date of most recent casting	

Electrical Stimulation:

Functional Electrical Stimulation (FES)? Yes ____ No ____

Date Initiated: _____ Current electrode placement: _____

Bioness? Yes ____ No ____

Date Initiated: _____ Current electrode placement: _____

Walk Aide? Yes ____ No ____

Date Initiated: _____ Current electrode placement: _____

Name: _____ DOB: _____

Neuro Surgeries:

	None		
	Selective Dorsal Rhizotomy	Date:	
	Intrathecal Baclofen Pump	Date placed:	
		Date removed:	
	Ventricular (VP) Shunt	Date:	

Orthopedic Surgeries:

✓	Surgery	Date
	None	
	SPML Hamstrings	
	SPML Gastrocs	
	SPML Adductors	
	PERCs Hamstrings	
	PERCs Gastrocs	
	PERCs Adductors	
	Tendon / muscle lengthenings Hamstrings	
	Tendon / muscle lengthenings Gastrocs	
	Tendon / muscle lengthenings Adductors	
	Hip Surgery: VRO	
	Hip Surgery: Pemberton	
	Hip Surgery: Dega	
	Derotation of femur	
	Derotation of tibia	
	Distal femoral extension osteotomy (for knee contracture)	
	8-plates (for knee contracture)	
	Upper extremity surgery elbow	
	Upper extremity surgery wrist/hand	

Tests:

What testing has been done to evaluate your child? Please provide date and results of most recent studies. * (Please send copies of reports and bring discs with MRI if possible, or sign a release for us to obtain.)

Test	Date	Location	Results
Hearing			
Eye Exam/Vision			
MRI Brain			
MRI Spine			
EEG			
Hip X-ray			
Spine X-ray			
Spinal Tap / CSF			
Genetics			
Other:			

Name: _____ DOB: _____

Past Medical History

Birth – Pregnancy, Labor, Delivery:

Mother's age at birth of patient: _____

Number of pregnancies (including this pregnancy, prior pregnancies, and miscarriages): _____

Prior premature delivery? Yes ____ No ____ If yes, how many: _____

History of still birth in past? Yes ____ No ____

Chronic illness in mother (select all that apply):

	None				
	Heart		Lung		Kidney
	Lupus		Rheumatoid Arthritis		Epilepsy
	Cerebral Palsy		Other Neurological Disease		
	Other illness:				

Was your child born at (select one)?:

	Term		Preterm

Was your child a (select one)?:

	Singleton		Twin		Triplet
	Quadruplet		Other		

Weeks Gestation: _____

Birth Weight: _____ Length: _____ Head Circumference: _____

Length of Labor (in hours): _____

Type of Delivery (select one):

	Spontaneous Vaginal		Induced Vaginal		C-Section with epidural
	C-Section under general anesthesia				

Apgars: at 1 min: _____ 5 min: _____ 10 min: _____

Home on DOL #: _____

NICU stay? Yes ____ No ____

Small for Gestational Age (IUGR)? Yes ____ No ____

Name: _____ DOB: _____

Congenital anomalies in baby (select all that apply):

	None		Brain Malformation		Heart
	Kidney-Urinary Tract		Limb		Spine
	Other:				

Complications during Pregnancy (Select all that apply):

	None						
	Vaginal Bleeding. If yes, when:						
	Blood clots in legs or in lungs						
	Uterine Infection. If yes (select one):		Bacterial		Viral		Unknown
	Bladder or Kidney infection						
	CMV infection						
	EBV infection						
	HSV infection						
	Fever						
	Threatened Miscarriage						
	Fetal Growth Restriction (IUGR)						
	Genetic abnormality						
	Twins- monozygous (identical)						
	In Vitro Fertilization						
	Abnormal Uterus shape						
	Uterine Fibroids						
	Placenta Previa						
	Preterm Labor						
	Preeclampsia						
	Maternal Diabetes						
	Trauma (e.g. motor vehicle accident/other). Describe:						
	Tobacco Use						
	Alcohol Use						
	Drugs						

Problems during labor/delivery (select all that apply):

	None
	Meconium in Amniotic fluid
	Abnormal Bleeding
	Placental Abruption
	Uterus Rupture
	Prolapsed Umbilical Cord
	Tight umbilical cord around neck
	Knot in umbilical cord
	Two Vessel Cord (instead of 3-vessel)
	Fever during labor/delivery
	Chorioamnionitis – inflammation of the placenta
	Abnormal Placenta
	Prolonged Shoulder Dystocia (shoulder stuck in birth canal)
	Other (describe):

Name: _____ DOB: _____

Neonatal History

What problems did your child have in the first month of life?

Heart:

	None		Congenital Heart Disease
	Heart Failure		Patent Ductus Arteriosis – PDA
	PDA requiring indomethacin		PDA requiring surgery
	Other:		

Lungs – Breathing:

	None		
	On ventilator – how many days:		
	On supplemental oxygen until DOL #:		
	Apnea and Bradycardia		Chronic Lung Disease
	Pneumonia		Pneumothorax
	Other:		

Brain:

	None		
	Seizures – starting on DOL #:		Meningitis
	Encephalitis		Bleeding in Brain
	Subdural		Epidural
	Intraventricular Hemorrhage		Brain Hemorrhage
	Stroke		PVL
	Cystic PVL		Hydrocephalus
	VP Shunt		Porencephaly
	Schizencephaly		Dandy Walker

Gastrointestinal:

	None		
	Necrotizing Enterocolitis (NEC)		GERD – vomiting/reflux
	Nissen Fundoplication		Liver failure or Liver injury
	Jaundice – high bilirubin		Phototherapy
	Feeding intolerance		G-tube
	Other (describe):		

Kidney:

	None		
	Kidney Failure or insufficiency		Kidney malformation
	Bladder or Ureter malformation		Kidney or bladder infection
	Other (describe):		

Blood-Immune System:

	None		Anemia
	Required transfusions		Sepsis – blood infection

Other:

	None		Colic
	Spinal abnormalities		Sleep problems

Name: _____ DOB: _____

Development:

What age did you first notice motor/movement problems? _____

Child's major difficulties (check all that apply):

	None		Speech Difficulty		Swallowing Difficulty
	Movement Difficulties		Tone Abnormalities		

Arm Weakness:

	None				
	Right		Left		Both

Leg Weakness:

	None				
	Right		Left		Both

What hand does your child prefer to use?

	Right		Left		No Preference

How old was your child when you could first see this hand preference?

	N/A				
	Younger than 1		1 to 2 years		Older than 2 years
	Other:				

Please list the age at which the patient performed the following or enter "N/A":

Skill	Age	Skill	Age
Rolled over front to back		Rolled over back to front	
Sat		Able to get into sitting from laying down	
Crawled, combat style		Crawled on hands and knees	
Stood dependently		Stood independently	

Walked with crutches		Walked with walker	
Walked with canes		Walked with gait trainer	
Walked independently		Ran	

Spoke first words		Spoke in sentences	
Used communication device		Uses Yes/No (words, signs or aug comm)	

Has your child lost any skills? Yes _____ No _____

If yes, describe when regression began and what skills have been lost:

Name: _____ DOB: _____

Activities of Daily Living (please check the appropriate box for each item):

	Independent	Partial Assistance	Dependent
Brush Teeth			
Comb Hair			
Bathe/Shower			
Feeds Self w/Fingers			
Feeds Self w/Utensils			
Drinks from Cup			
Toileting:			
Day			
Night			
Dressing:			
Upper Body			
Lower Body			
Buttons			
Snaps			
Shoes			
Socks			
Braces			

How long does it take for your child to dress? _____

Frequency of dressing themselves:

	Every Day		Only on Weekends		N/A

Accessibility:

How accessible is your home?

Entrance(stairs)

Living area

Storage

Doorways

Interior space

Bathroom

Toilet

Tub/Shower

Lift

Name: _____ DOB: _____

Sleep Habits:

Total hours of sleep per night: _____

Sleep in: Bed _____ Crib _____

Do they sleep alone in room? Yes _____ No _____

Shares bed?

	No		With Sibling		With Parent

Time to:

Bed: _____

Sleep: _____

Awake: _____

Awakens self in AM? Yes _____ No _____

Wakes up during night? Yes _____ No _____ If yes, number of times: _____

Position child usually sleeps in:

	Back		Side		Stomach

Nighttime tube feedings? Yes _____ No _____

Nighttime devices:

	None						
	Braces		Knee Splints		Foot Splints		Arm Splints

Comments:

Name: _____ DOB: _____

School:

Name			
Address			
Phone		Teacher's Name	

Current grade level: _____ Grade level child functions at: _____

	Regular Classes		Special Ed		Resource Room Support

Neuropsych Testing: Date of most recent testing_____
(Provide copy if possible)

Specific problems:

	Attention Difficulties		Behavior		Learning (reading, math)
	Organizational		Visual Spatial		Sensory Integration

Date of **last** IEP: _____ Date of **next** IEP:_____

Home Schooled? Yes _____ No _____

Home Bound Education? Yes _____ No _____

FAMILY HISTORY :

Do any of other family members have neurological problems or other illness?

Yes _____ No _____

If yes, select all that apply:

	dystonia		spasticity		movement difficulties
	cerebral palsy		seizures		cognitive disability
	walking problems		stiffness		foot deformities
	weakness		strokes		other limb con/ deformity
	heart disease		diabetes		hearing problems
	autoimmune disease		arthritis		osteoporosis
	fractures (broken bones)				

SOCIAL HISTORY :

Siblings (how many in household): _____

Who does the patient live with? _____

If child is 13 yrs or older, do they smoke? Yes _____ No _____

do they drink alcohol? Yes _____ No _____

Name: _____ DOB: _____

Names of other specialists and locations:

Orthopedist _____ Eye Doctor _____

Cardiologist_____ Urologist _____

Other(s)_____

Have you requested these records to be sent to us? Yes _____ No _____

If yes, when? _____

Are you currently seeing, or have you seen any other physician(s) related to your child's difficulties? Yes _____ No _____ (If yes, please list)

Form filled out by:

	Patient (if adult)		Parent		Legal Guardian
	Other (specify):				

I hereby certify the above information to be true and accurate to the best of my knowledge.

_____ _____

Signature of Patient/Parent/Guardian Date

_____

Print name of Patient/Parent/Guardian