The Children's Hospital of Philadelphia
Division of Neurology
34th Street and Civic Center Boulevard
Philadelphia, PA 19104-4399
215-590-1719

Neuromuscular Program Enrollment Form

Patient Name: _____

Date of Birth:_____/____/_____ Current age: _____

1. CHOP Patient ID number, if you have one: _____
2. Person completing this form:_____
   a. Your mailing address: _____
      _____
      _____
   b. Your phone number:
      at home: (_____)_____ (best time to reach me is from _____ to _____)
      at work: (_____)_____ (best time to reach me is from _____ to _____)
   c. Your email:_____
3. Who referred you? _____
4. What are your concerns or questions that you want addressed when you come to the Neuromuscular Clinic?
   a. _____
   b. _____
   c. _____
5. Is there a specific doctor in this clinic that you have been referred to or wish to see?

   Yes☐ No ☐ If yes, please specify: _____

   If another doctor in the clinic has a sooner appointment, do you want that instead?
   Yes☐ No ☐ If no, I would like to wait longer to see the specific doctor I want.

6. Our clinic has multiple service providers. In order to best service your child please indicate if you would like an assessment or discussion with a:
   Yes☐ No ☐ Genetic counselor
   Yes☐ No ☐ Physical Therapist
   Yes☐ No ☐ Occupational Therapist
   Yes☐ No ☐ Social Worker
   Yes☐ No ☐ Nutritionist or feeding specialist
   Yes☐ No ☐ Orthopedic surgeon
   Yes☐ No ☐ Cardiologist (heart specialist)

Yes☐ No ☐ Pulmonologist (lung and breathing specialist)
Yes☐ No ☐ Rehabilitation specialist
Yes☐ No ☐ Representative from the Muscular Dystrophy Association (MDA)

7. Please forward to us **IN ADVANCE OF YOUR APPOINTMENT**, any of the following studies or reports, if done previously:
   a. From your primary care physician: growth charts, relevant medical history
   b. All hospital discharge summaries
   c. Reports of any MRI scans, EEG studies, electromyography (EMG) or nerve conduction studies, muscle or nerve biopsy, genetic testing blood or spinal fluid tests, X-rays, swallowing or feeding studies. If any of these were abnormal, then please bring the actual test (films, biopsy slides) as well for our review.
   d. Reports of all prior specialist evaluations.

8. Are there any privacy issues that we need to be aware of? _____

9. Are there other major circumstances in your life we should know about (recent deaths, births, illness of other family members, etc.)? _____

10. Please list an emergency contact - someone who is a support to you and your child:
    Name and relationship: _____
    Address: _____
    Phone number: _____

11. **Are there any financial or health insurance issues** that may make it difficult for you to come to this clinic? If so, our social worker, Alan Tuttle (215-590-6875) may help you to work this out prior to the visit.

12. **Are there any transportation problems** that may make it difficult for you to get to the clinic? If so, our social worker, Alan Tuttle (215-590-6875) may help you to work this out prior to the visit.

13. Are there any other medical appointments or testing at CHOP that you would like to schedule for the same day?

14. Is there any legal aspect to your consultation? If so, we must speak with your attorney first to clarify the purpose of the consultation and how it should be handled.
    No ☐Yes☐ Attorney's name and phone number: _____

15. To whom should we send our report (i.e., healthcare providers):

1.	2.	3.

Please fill out the following health questionnaire.
If you do not know the answer to a question, indicate this by writing "?" in the space provided.

1. What was your child's birth weight? _____pounds, _____ounces *or* _____kg
2. What was your child's length at birth? _____inches *or* _____cm
3. What was your child's head circumference at birth? _____inches *or* _____cm

Was your child born prematurely? Yes☐ No ☐

a. what was the gestational age? _____ weeks.

5. Were there any complications of the pregnancy, labor or delivery (if yes, please explain)?

Yes☐ No ☐ a. infection _____
Yes☐ No ☐ b. bleeding_____
Yes☐ No ☐ c. pre-term labor_____
Yes☐ No ☐ d. prescription medications_____
Yes☐ No ☐ e. mother's use of tobacco, alcohol or drugs _____
Yes☐ No ☐ f. exposure to toxins or radiation _____
Yes☐ No ☐ g. trauma _____
Yes☐ No ☐ h. was there good "kicking" (fetal movement)? _____
Yes☐ No ☐ i. do you know the baby's "APGAR" scores at birth? ____1 min,_____ 5 min
Yes☐ No ☐ j. did the baby need oxygen or resuscitation in the delivery room?
_____
Yes☐ No ☐ k. did the baby go to the intensive care nursery (NICU)? _____
Yes☐ No ☐ l. did the baby need breathing support (oxygen, CPAP or ventilator)?
_____
Yes☐ No ☐ m. was the baby treated for infection? _____
Yes☐ No ☐ n. was the baby treated for jaundice with phototherapy? _____
Yes☐ No ☐ o. did the baby needed a blood transfusion? _____
Yes☐ No ☐ p. did the baby have a seizure? _____
Yes☐ No ☐ q. did the baby need to be fed by a tube? _____
Yes☐ No ☐ r. was the baby "floppy" (low muscle tone)? _____
Yes☐ No ☐ s. was the baby born with tight joints, hip or spine problem, or have a bone fracture? _____

6. Has your child ever been hospitalized (if yes, please explain)?

Yes☐ No ☐ a. for an illness? _____
Yes☐ No ☐ b. for surgery? _____
Yes☐ No ☐ c. any reaction to anesthesia? _____
Yes☐ No ☐ d. for diagnostic testing? _____
Yes☐ No ☐ e. for trauma? _____

7. Does your child take nutritional supplements, vitamins or have a restricted diet? Yes☐ No ☐

_____

8. Has your child ever needed to take prescription medication, for more than one month, for a medical condition? Yes☐ No ☐:

Name of Medication	Age	Taken Dosage
1.		
2.		
3.		

9. Does your child have any allergies to medication? Yes ☐ No ☐: _____

10. **Digestive.** Does/did your child:
- Yes ☐ No ☐ a. have any feeding problems? _____
- Yes ☐ No ☐ b. have difficulty with weight gain? _____
- Yes ☐ No ☐ c. have "reflux"? _____
- Yes ☐ No ☐ d. need tube feeding at home? _____
- Yes ☐ No ☐ e. have a swallow study? _____
- Yes ☐ No ☐ f. eat all consistencies of food (pureed, pasta, meat)? _____

11. **Lungs.** Has your child:
- Yes ☐ No ☐ a. ever needed oxygen use at home? _____
- Yes ☐ No ☐ b. ever been treated for pneumonia or a lung infection? _____

12. **Heart**. Has your child:
- Yes ☐ No ☐ a. ever been diagnosed with a murmur, heart defect, heart failure or other heart problem? _____
- Yes ☐ No ☐ b. had an EKG, echocardiogram or Holter monitor study? _____

13. **Bones.** Has your child:
- Yes ☐ No ☐ a. ever been diagnosed with a curvature of the spine (scoliosis, kyphosis, lordosis)? _____
- Yes ☐ No ☐ b. had X-rays taken? _____
- Yes ☐ No ☐ c. ever seen an orthopedic doctor? _____
- Yes ☐ No ☐ d. had arthritis or joint problems (contractures)? _____

14. **Muscles.** Has your child:
- Yes ☐ No ☐ a. ever said to be "floppy" or low tone? _____
- Yes ☐ No ☐ b. been slow developing motor/muscle skills? _____
  - when did your child roll over completely (age)? _____
  - sit independently? _____
  - walk unaided? _____
  - climb stairs? _____
  - jump? _____
- Yes ☐ No ☐ c. received physical therapy (PT)? _____
- Yes ☐ No ☐ d. had any regression of motor development? _____
- Yes ☐ No ☐ e. showed lack endurance and need to rest frequently? _____
- Yes ☐ No ☐ f. complained of muscle pain? _____

Yes☐ No ☐ g. been slow in developing fine motor (hand use) skills? _____
- is there an established hand preference? _____
- are there tremors or clumsiness? _____
- received occupational therapy (OT)? _____

Yes☐ No ☐ h. had blood testing for a muscle disorder? _____
- creatine kinase (CK): (dates/results) _____
- specific genetic tests: (dates/results) _____

Yes☐ No ☐ i. had an EMG (electromyography) or nerve conduction study performed? _____

Yes☐ No ☐ j. had a muscle or nerve biopsy performed? (result) _____

15. Are there problems with vision or hearing? Yes☐ No ☐ _____
Yes☐ No ☐ a. has your child seen an eye doctor? If yes, when (date)? _____
Yes☐ No ☐ b. has your child had the hearing tested? If yes, when (date)? _____

16. Is there any difficulty with speech or communication? Yes☐ No ☐ _____
Yes☐ No ☐ a. has your child received speech therapy? _____

17. Does your child have any sleep problems? Yes☐ No ☐ If yes, explain.

_____

18. Does your child have any behavioral problems? Yes☐ No ☐ If yes, explain.

_____

19. Does your child seem to have cognitive (thinking, reasoning, remembering, learning) delays?
Yes☐ No ☐ _____

20. Does your child have any academic difficulties at school? Yes☐ No ☐
a. had a 504, CER or IEP completed?: Yes☐ No ☐ (please bring to the clinic visit)
b. received any special services at school? Yes☐ No ☐ _____

21. Genetics.
Yes☐ No ☐ a. does anyone in your family (cousins, uncles,…) have conditions similar to your child? _____
Yes☐ No ☐ b. are the mom and dad related? (exact relationship) _____
c. what is the ethnic origin of mom _____and dad _____
d. are there any family members (brother, cousin, aunt,…) with:
Yes☐ No ☐ ▪ nerve or muscle disorders? _____
Yes☐ No ☐ ▪ known genetic syndromes? _____
Yes☐ No ☐ ▪ known metabolic conditions? _____
Yes☐ No ☐ ▪ children who died unexpectedly? _____
Yes☐ No ☐ ▪ multiple miscarriages or a stillbirth? _____
Yes☐ No ☐ ▪ birth defects? _____
Yes☐ No ☐ ▪ learning disabilities or mental retardation? _____

22. Has your child ever participated in a clinical research trial? Yes☐ No ☐ If yes, please list.

_____

23. If a treatment trail is available for your child's condition would you be interested in learning more about it? Yes☐ No ☐

Request for insurance information:

Insurance Co._____ Phone # _____
ID# _____ Group _____
Subscriber Name:_____ Effective Date_____

Thank you for completing this form. Please mail or fax it to:

Neuromuscular Program Coordinator
Division of Neurology – 6 Wood Center
The Children's Hospital of Philadelphia
34th Street and Civic Center Blvd
Philadelphia, PA 19104
Fax: 215-590-2223

You will be contacted for an appointment for your child within one week of us receiving the completed questionnaire. If you do not hear from us, please contact Neurology at 215-590-1719.