CONCORD CHILDREN'S CLINIC
PARENT REVIEW FORM

Patient Name ----------

Date of birth _____ ____Date of Evaluation_____

Parent Concern _____

_____

Current living arrangements _____

Behavior at home _____

Peer relations/ social skills_____

Activities & involvements_____

School history_____☐ At Grade Level _____☐ Below _____☐ Above _____

Current school attending_____Grade_____

Contact person at school_____☐ Counselor _____☐ Teacher _____

Current academic process_____

Special classes' _____

Repeated grades _____

Previous testing and evaluation_____

Management strategies to current problems _____

_____

Family history

Yes	No		Yes	No	
○	○	Cardiac Arrhythmia	○	○	Cardiomyothpathies
○	○	Long or short QT syndrome	○	○	Abnormal rhythm problems
○	○	Syncope requiring resuscitation	○	○	Marfans Syndrome
○	○	Learning disability	○	○	Depression
○	○	Alcoholism	○	○	ADHD
○	○	Bipolar	○	○	Other mental problems
○	○	Sudden or unexplained death of young family member			
○	○	Heart attack of a family member less than 35 yrs of age			

Patient History

Yes	No		Yes	No	
○	○	History of fainting or dizziness with exercise	○	○	Seizures
○	○	Chest pain for shortness of breath with exercise	○	○	Rheumatic fever
○	○	Palpitation or irregular heart beat	○	○	TIC disorder
○	○	History of high blood pressure	○	○	Sleep problems
○	○	History of heart murmur	○	○	History of heart problems
○	○	Head trauma			

Current Meds ____

Health Supplements ____