NEUROFIBROMATOSIS CLINIC PRE-VISIT ASSESSMENT

School Age

GENERAL

Does your child have a primary care physician?  YES  NO
Name:

How often does your child see his or her primary care physician?

Does your child see any other specialists?  YES  NO
List:

Does your child have any other known medical problems?  YES  NO

Does your child see a dentist regularly?  YES  NO

NEUROFIBROMATOSIS ASSESSMENT

Have you noticed more birthmarks developing or growing in size?  YES  NO

Have you noticed freckles in your child's armpits or leg creases (groin area)?  YES  NO

Have you noticed the development of any lumps, bumps, or swellings on your child?  YES  NO
  If yes, are these painful, tender, or itchy?  YES  NO

Does your child complain of any other pain?  YES  NO

Does your child have trouble with his or her vision?  YES  NO

GENERAL HEALTH ASSESSMENT

Does your child's heart race?  YES  NO

Does your child ever faint?  YES  NO

Does your child throw up frequently?  YES  NO
Have you noticed pubic hair, early breast development, or body odor on your child?  

YES  NO

Has your child ever had a seizure?  

YES  NO

Does your child ever have stomach or abdominal pain?  

YES  NO

Does your child have frequent headaches?  

YES  NO

Has your child ever been evaluated for slow growth?  

YES  NO

Is your child losing weight?  

YES  NO

Are you concerned with your child’s weight: either weighing too much or eating less?  

YES  NO

Are you concerned with the quality of your child’s diet?  

YES  NO

Would you like to meet with a dietitian?  

YES  NO

MENTAL/EMOTIONAL HEALTH ASSESSMENT

Is your child currently experiencing emotional difficulties, like periods of sadness, irritability, fearfulness, or worry?  

YES  NO

Does your child feel angry or frustrated easily?  

YES  NO

Does your child experience nightmares?  

YES  NO

Does your child feel hopeful about the future?  

Does your child feel lonely or isolated?  

YES  NO

Has your child had thoughts of suicide?  

YES  NO

Does your child avoid certain situations or people in order to reduce reminders of his or her NF?  

YES  NO

Does your child think about NF more than he or she wants to?  

YES  NO

Does your child have any other concerns for which you would like to meet with a psychologist?  

YES  NO
SLEEP ASSESSMENT

Does your child wet his or her bed? 
YES  NO

Does your child have trouble with sleep? 
YES  NO

How many hours does your child sleep? 

Does your child experience nightmares? 
YES  NO

SCHOOL ASSESSMENT

Does your child seem to need help staying on task when doing challenging activities or schoolwork? 
YES  NO

Does your child have trouble remembering to complete daily tasks, homework, household responsibilities, phone numbers or important dates? 
YES  NO

Has your child ever been diagnosed with or treated for emotional or behavioral difficulties, like depression, anxiety, or ADHD? 
YES  NO

What grade level is your child?

Does your child spend more time than his or her peers on homework? 
YES  NO

Is your child reading at grade level? 
YES  NO
If not, what level?

Are your child’s math skills at grade level? 
YES  NO
If not, what level?  ________________

Does your child have any educational services in place? 
YES  NO

If yes, are you happy with the help that your child’s school provides?  ________________

What concerns do you have concerning the help your child is receiving?  ________________

Has your child ever had a special educational evaluation by his or her school or by a Neuropsychologist? 
YES  NO
## MOTOR DEVELOPMENT

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your child pronounce words differently than other people, or have trouble pronouncing certain words?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Does your child have difficulty with activities of daily living, like handwriting, tying shoes, picking up or handling coins, or managing clothing fasteners?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Does it seem like your child always needs to be moving?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Does your child seem to take unnecessary risks?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Does your child seem to need help staying on task when doing enjoyable activities?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Does your child have any other concerns for which you would like to meet with an occupational therapist?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Does your child have difficulties going up or down stairs, getting in or out of a car or bed, or walking long distances?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Does your child have problems with balance or require assistance when walking on uneven surfaces, such as grass or dirt?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Does your child seem slower than the other kids when running?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Can your child ride a bicycle?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Is your child able to keep up with peers when playing sports?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Does your child get 60 minutes of activity per day?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Does your child shy away from group sports?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Does your child have any other concerns for which you would like to meet with a physical therapist?</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>