CPCHECKlist©
(Caregiver Priorities - Comorbidities and Health Evaluation Checklist)

The CPCHECKlist© is a list of health concerns about your child that you can bring to the attention of health care providers.

Please indicate how YOU think your child is doing for each health issue listed below, and whether any of these are a concern or goal you wish to address.

If you have a health concern that is not listed, please highlight it in the "other health issues of concern" section (item 25).

						For each health issue: Is this a concern or a goal you wish to address at this time?		
						Not a concern or goal	**Somewhat a concern or goal**	**Important concern or goal**
1. Seizures	Never had seizures	No seizures in the last year	Seizures- controlled	Seizures- poorly controlled	Unsure/ Don't know			
2. Sleeping difficulties (e.g., falling asleep, too little or too much sleep, frequent waking, timing of sleep)	None	Some	A lot					
3. Mood/behaviour problems	None	Some	A lot					
4. Vision (with glasses, if used)	Normal	Moderately impaired/ reduced	Severely impaired/ blind	Unsure/ Don't know				
5. Hearing (with aids, if used)	Normal	Moderately impaired/ reduced	Severely impaired/ deaf	Unsure/ Don't know				
6. Drooling	None	Some	A lot					
7. Dental (teeth, gums) problems	None	Some	A lot	Unsure/ Don't know				
8. Swallowing problems (e.g., choking, gagging, aspiration, food/liquids going down the wrong way)	None	Some	A lot	Unsure/ Don't know				
9. Breathing difficulties (e.g., wheezing, snoring, apnea/breath holding, chest congestion)	None	Some	A lot					

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10. Pneumonia (in the last 12 months)	None	Yes, without hospitalization	Yes, with hospitalization	Yes, requiring intubation				
11. Gastroesophageal reflux (e.g., acid reflux, heart burn, spit-up, regurgitation, vomiting)	None	Some	A lot	Unsure/ Don't know				
12. Feeding difficulties: Please select all routes of feeding that apply <u>AND</u> identify the amount of difficulty	○ Oral (by mouth) ○ NG-tube (through nose) ○ G-tube ○ GJ-tube ○ Intravenous (IV/TPN)	None	Some	A lot	Unsure/ Don't know			
13. Nutritional problems (e.g., under/ overweight)	None	Some	A lot	Unsure/ Don't know				
14. Bowel/bladder control	Toilet trained	Some control	No voluntary control (full time in diaper/ nappy)					
15. Bowel movement problems (e.g., constipation/diarrhea)	None	Some	A lot					
16. Bladder/urinary problems (e.g., infection, stones, retention)	None	Some	A lot	Unsure/ Don't know				
17. Uncontrolled (involuntary) movements of the limbs, neck, or trunk/body	None	Some	A lot					

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18. Contractures (stiff muscles or joints) or pain of the **arm (shoulder, elbow, wrist, or fingers)** that interfere with caregiving or functioning	None	Some	A lot	Unsure/ Don't know				
19. Increased curve or twist of the **back/spine** (e.g., scoliosis)	None	Some	A lot	Unsure/ Don't know				
20. Contractures (stiff muscles or joints) or pain of the **hip** that interfere with caregiving or functioning	None	Some	A lot	Unsure/ Don't know				
21. Contractures (stiff muscles or joints) or pain of the **leg (knee, ankle, or foot)** that interfere with caregiving or functioning	None	Some	A lot	Unsure/ Don't know				
22. Other sources of pain/discomfort	None	Some	A lot					
22b. Please specify the location/s: *Only if responded "some" or "a lot" to item 22								
23. Fractures/broken bones (in the last 2 years)	None	Once	More than once					
24. Skin problems (e.g., redness, rashes, blisters, wounds, pressure sores)	None	Some	A lot					
24b. Please specify the location/s: *Only if responded "some" or "a lot" to item 24								
25. Please specify any other health issues you have concerns about:								

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CPCHECKlist© - Health Technology

For each device or health technology your child uses, do YOU think there is a problem or concern that needs to be addressed at this time?

	Does not use (N/A)	No problem or concern	Yes, there is a problem or concern
1. VP/VA (brain) Shunt			
2. Tracheostomy			
3. Breathing aids/devices (e.g., oxygen, CPAP, BiPAP, ventilator)			
4. Hearing aids/cochlear implant			
5. Communication device/aid			
6. Feeding tube (e.g., NG-tube, G-tube, GJ-tube, IV)			
7. Intrathecal baclofen pump (ITB)			
8. Deep brain stimulator (DBS)			
9. Seating/transport/mobility aids (e.g., wheelchair, power chair)			
10. Walking aids (e.g., walker)			
11. Exercise equipment (e.g., stander, supportive walker/gait trainer)			
12. Orthotics or braces (e.g., AFOs, splints, positioning devices)			
13. Other aids/technology. Please specify: _______________			

Please select any of the devices or health technologies that your child does <u>not</u> use, that you would like to discuss or learn more about:

- ○ None
- ○ VP/VA (brain) shunt
- ○ Tracheostomy
- ○ Breathing aids/devices (e.g., oxygen, CPAP, BiPAP, ventilator)
- ○ Hearing aids/cochlear implant
- ○ Communication device/aid
- ○ Feeding tube (e.g., NG-tube, G-tube, GJ-tube, IV)
- ○ Intrathecal baclofen pump (ITB)
- ○ Deep brain stimulator (DBS)
- ○ Seating/transport/mobility aids (e.g., wheelchair, power chair)
- ○ Walking aids (e.g., walker)
- ○ Exercise equipment (e.g., stander, supportive walker/gait trainer)
- ○ Orthotics or braces (AFOs, splints, positioning devices)
- ○ Other aids/technology: _____________________

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