Pediatric Patient History Form

What name does your child prefer to be called? _____

When did your child's current problem begin? (Date of onset) _____ Date of surgery _____

Describe your child's current problem(s): _____

_____

Our goal for therapy is: _____

Current School Name/Grade: _____

❑ Pre-school ❑ Mother's Day Out ❑ Other: _____

Functional Limitations:

Please check the activities your child is having trouble performing because of this problem:

❑ Rolling ❑ Sitting ❑ Standing ❑ Going from one position to another
❑ Basic self care ❑ Feeding/eating ❑ Dressing
❑ Walking ❑ Crawling
❑ Leisure/Play activities _____
❑ Talking ❑ Understanding
❑ Other: _____

Is your child using any equipment to assist him/her since the injury? ❑ walker ❑ wheelchair
❑ crutches ❑ bedside commode ❑ Other: _____

Has your child been treated for this problem before? ❑ No ❑ Yes when: _____
❑ Inpatient Rehab ❑ Outpatient Therapy ❑ ECI ❑ Other: _____

Is your child currently receiving other health services for this problem? ❑ No ❑ Yes _____

❑ Recent tests: ❑ X-ray ❑ MRI ❑ CT-scan ❑ Modified Barium Swallow Study ❑ Upper GI
❑ Hearing ❑ Other: _____
Results: _____

When is your child's next appointment with the physician regarding this problem?_____

Medical History:

Does your child have or had any of the following? (Please check all that apply)

Heart disease	❑ No	❑ Yes	Sinus/cough/asthma	❑ No	❑ Yes
Congestive Heart Failure	❑ No	❑ Yes	Pneumonia/Bronchitis	❑ No	❑ Yes
Pulmonary Disease	❑ No	❑ Yes	Stomach/Digestive problem	❑ No	❑ Yes
Premature Birth	❑ No	❑ Yes	Kidney/Bladder problem	❑ No	❑ Yes
Active infection	❑ No	❑ Yes	Sleep disorder	❑ No	❑ Yes
Cancer	❑ No	❑ Yes	Stroke/Seizures/Epilepsy	❑ No	❑ Yes
If yes, what type: _____			Spine/Back/Neck problem	❑ No	❑ Yes
Visual Impairments	❑ No	❑ Yes	Arthritis	❑ No	❑ Yes
Feeding Disorder	❑ No	❑ Yes	Hepatitis/Liver disease	❑ No	❑ Yes

Developmental Delay ❑ No ❑ Yes Autism/PDD/ADD/ADHD ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes Learning Disability ❑ No ❑ Yes

If yes, does your child check his/her own blood sugar? ❑ No ❑ Yes

Does your child have allergies? ❑ No ❑ Yes If so, please list: _____

_____

Does your child follow a special diet? ❑ No ❑ Yes If so, what diet: _____

Has your child had recent unexplained weight loss or gain in the last 6 months? ❑ No ❑ Yes

If so, how much _____ how long _____

At the present time, would you say that your child's health is? ❑ Excellent ❑ Very good ❑ Fair ❑ Poor

Within the last year, have you or your child been physically or emotionally abused? ❑ No ❑ Yes

Do you/your child feel unsafe in your home environment? ❑ No ❑ Yes

Do you/your child feel unsafe with your caretakers? ❑ No ❑ Yes

Does your child have a learning disability ❑ No ❑ Yes

My child has problems learning because of: ❑ Sight ❑ Hearing ❑ Language barrier ❑ Other _____

Do you or your child have any spiritual, cultural, or ethnic beliefs/practices that we should be aware of in order to care for your child? ❑ No ❑ Yes If yes, please describe _____

Current residence: ❑ House ❑ Apartment ❑ Other: _____

Steps ❑ No ❑ Yes How many?_____

Do you/your child need assistance at home? ❑ No ❑ Yes From: ❑ Spouse/Significant Other

❑ Family ❑ Other: _____

Please list any medications your child is currently taking:

_____

_____

_____

Please list any surgeries:

_____

_____

_____

_____

Information completed by: _____ ❑ Parent ❑ Other: _____

Patient information reviewed and validated with the patient/significant other/caregiver.

Signature of therapist: _____ Date: _____