PEDIATRICS UNLIMITED INC

Occupational / Physical / Speech Therapy
PEDIATRIC CASE HISTORY

Date:_____

Patient's Name_____ Nickname_____Date Of Birth_____

[ ] Male [ ] Female SS#_____ Home #_____ _

Street Address_____City_____State_____Zip Code_____

Referral Source_____Referral Source Phone #_____

Reason for Referral_____

Child's Doctor_____Phone #_____

Other Doctors who provide care to this child_____Specialty_____

Other Doctors who provide care to this child_____Specialty_____

Emergency Contact Person (Name, relationship, phone number)_____

All information given in this questionnaire is considered strictly confidential.

Mother's Name_____Age_____Marital Status_____

Work Phone #_____Cell Phone #_____ Email Address _____

Highest Level of Education_____Occupation_____

History of Learning or Motor Problems?_____ If Yes, please explain. _____

_____

Father's Name_____Age_____Marital Status_____

Work Phone #_____Cell Phone #_____ Email Address _____

Highest Level of Education_____ Occupation_____

History of Learning or Motor Problems?_____ If Yes, please explain. _____

_____

Brothers and Sisters

Name	Age	Developmental, Speech, Hearing or Medical Problems

Has your child received any previous therapy? [ ] yes [ ] no

If "Yes", when and where?_____

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Had a vision test? _____Yes _____No If yes, results & when:_____

Had a hearing test? _____Yes _____No If yes, results & when:_____

Has your child received other evaluations (psychological, educational, neurological…)?

Type_____Eval. Date_____Professional's Name_____

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PRENATAL AND BIRTH HISTORY

Check any of the factors below that apply:

_____ need for hospitalization or bed rest _____ excessive vomiting _____ drug use

_____ alcohol use _____ diabetes _____ excessive weigh loss

_____ smoking _____ premature rupture of the membranes _____ hemorrhaging

_____ medications _____ trauma/injuries _____ excessive weight gain

_____RH incompatibility _____previous miscarriages _____high blood pressure

_____measles _____polyhydraminos _____ breach delivery

_____ cesarean delivery

Length of Pregnancy_____Length of Labor_____Birth Weight_____Apgar Scores_____

Please describe any other difficulties with the pregnancy or birth of your child_____

_____

If premature birth, any complications? (e.g.,pulmonary suffactant use, necrotizing enterocolitis, retinopathy of prematurity, intraventricular hemorrhage?)

Was the child in the Neonatal ICU? [ ] No [ ] Yes: how long? _____

CHILD HEALTH HISTORY

Has your child had any of the following? If yes, describe and give approximate dates. Check any illnesses and your age at which it occurred.

[ ] adenoidectomy _____ [ ] allergies _____ [ ] asthma _____

[ ] bronchitis _____ [ ] chicken pox _____ [ ] chronic colds _____

[ ] ear infections _____ [ ] headaches _____ [ ] heart trouble _____

[ ] measles _____ [ ] meningitis _____ [ ] pneumonia _____

[ ] reflux _____ [ ] seizures_____ [ ] sinus trouble _____

[ ] tonsillectomy _____ [ ] tubes in ears _____ [ ] Lead exposure _____

[ ] other _____

Diagnoses _____

Congenital Abnormalities_____

Surgery_____

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Other hospitalizaitons_____

Casts or braces_____

List any medications your child is currently taking_____

_____

Circle all that apply: glasses, braces, splints, hearing aids, augmentative communication device, wheelchair?

FAMILY HEALTH HISTORY

Family members with medical problems (please list what relation and what type of problem):

_____

_____

Family members with conditions that affect behavior or cognition/learning: (E.g., Tourette's, ADHD, Learning Disabilities, Autism)

_____

_____

Family members with genetic conditions: (E.g., Turner's Syndrome, Fragile X, Marfan Syndrome, Velo-Cardio-Facial Syndrome)

_____

_____

Any family history of: please check all that apply:

___depression ___bipolar mood disorder ___anxiety ___phobias ____psychosis/schizophrenia

SCHOOL

Teacher's Name:_____School_____Grade in School:_____

What kinds of grades does your child achieve? _____

What subjects does your child have difficulty with?_____

Has your child ever repeated a grade? When?_____

Has your child's grades changed? If so, when and how?_____

_____

Does your child receive any school services? Check all that apply.

___IEP _____IFSP ____special education classroom full day

___special education services in the regular education classroom ___ Early Intervention kindergarten classroom

___Section 504 Plan ___tutoring

___classroom aide ___career center/vocational rehab

Has your child ever missed more than 10 days of school in a year? [ ] Yes [ ] No

If yes, when and why? _____

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Has your child ever been suspended or expelled? [ ] Yes [ ] No

If yes, when and why? _____

How far do you hope your child will go in school? _____

What do you hope your child will be when he/she grows up? _____

FAMILY EXPECTATIONS

How, if any way, would you like to interact differently with your child?_____

_____

What information would you like to know more about?_____

_____

What would you like your child to achieve in the next 6 months?_____

_____

How did you hear of our clinic?_____

Signature_____

Thank you! Your insights will help us to do our best for you!

MP_11/24/2014