PEDIATRICS UNLIMITED INC

Occupational / Physical / Speech Therapy
PEDIATRIC CASE HISTORY

Date:_____

Patient's Name_____ Nickname_____ Date Of Birth_____

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

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_____

All information given in this questionnaire is considered strictly confidential.

Parent/Legal Guardian Name_____Age_____Marital Status_____

Relationship to Patient_____

Work Phone #_____Cell Phone #_____Email Address _____

Highest Level of Education_____Occupation_____

History of Learning or Motor Problems? [ ] yes [ ] no If Yes, please explain. _____

Parent/Legal Guardian Name_____Age_____Marital Status_____

Relationship to Patient_____

Work Phone #_____Cell Phone #_____Email Address _____

Highest Level of Education_____Occupation_____

History of Learning or Motor Problems? [ ] yes [ ] no If Yes, please explain. _____

Brothers and Sisters

Name	Age	Developmental, Speech, Hearing or Medical Problems

Has your child received any previous OT, PT, or Speech Therapy? [ ] yes [ ] no

If "Yes", which one(s), when and where?_____

Has your child received other evaluations (OT, PT, ST, 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 a vision test? [ ] yes [ ] no If yes, results & when: _____

Had a hearing test? [ ] yes [ ] no If yes, results & when: _____

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 _____

Other hospitalizations _____

Casts or braces _____

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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/health problems (please list what relation):

[ ] Tourette's Syndrome _____ [ ] ADD/ADHD _____ [ ] Autism _____

[ ] Learning Disabilities_____ [ ] Turner's Syndrome___ [ ] Fragile X Syndrome _____

[ ] Marfan Syndrome _____ [ ] Down Syndrome_____ [ ] Cleft lip/palate_____

[ ] Depression _____ [ ] Anxiety _____ [ ] Phobias _____

[ ] Bipolar Mood Disorder_____ [ ] Psychosis_____ [ ] Schizophrenia_____

[ ] Other _____

SCHOOL (if applicable)

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? [ ] yes [ ] no If yes, when? _____

Have your child's grades changed? [ ] yes [ ] no If yes, 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? _____

Has your child ever been suspended or expelled? [ ] Yes [ ] No If yes, when and why? _____

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?_____

Parent/Legal Guardian Signature_____

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

Patient's Name: _____ Date of Birth: _____