Pediatric Specialty Services

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Pediatric Physical Medicine & Rehabilitation Patient Information

Child's Name_____ Date of Birth_____ Today's Date_____

Your Name/Relationship to Patient_____

Child's Primary Care Doctor _____ Phone_____

Child's Referring Doctor_____ Phone_____

Child's main health condition or diagnosis_____

Reason for today's visit_____

Pharmacy name and address_____

Current Medications (may attach list)

Medication	**Dosage (# cap/tab/ml)**	**How often?**

Is your child allergic to any medications? YES NO If yes, please list:_____

Has your child had all the immunizations required for his/her age? **YES NO NOT SURE**

Birth History

Birth Weight_____ Born at _____Weeks

Number of children_____ Patient order of birth_____

What were the significant events surrounding your child's birth?_____

How long was your child in the Nursery/NICU?_____

Past Medical History

Please list any hospitalizations, surgeries, or past medical tests, including MRIs, swallow tests, or x-rays of the hips or spine.

Age/Date	Treatment and Result

Does your child have any of the following medical issues? (Please circle)

Epilepsy	Autism	Drooling or excessive salivation
Constipation	GI Reflux	Accidents of bowel or bladder
Spine problems	Hip problems	Feet problems
Diet restrictions	Sleep problems	Recurrent asthma, bronchitis, or pneumonia
Swallowing problems		Pain (Where?_____)

Family History

Are there medical conditions that run in your family?_____

Please list the relationship of any relative who has the following and specify mother's or father's side.

Bleeding disorder	Cancer
Diabetes	Stroke
Nerve or muscle disease/disorder	Chronic pain
Arthritis	Problems with anesthesia

Social History

Who lives at home with your child? (adults, children, pets…)_____

Extracurricular activities?_____How many stories does your home have? **One** **Two**

(Circle one) Does your child take regular classes, special classes, or combination classes? Grade_____

What supports, if any, does your child have at school? _____

Developmental History At what age did your child first:

Roll over_____	Sit without help_____	Crawl_____	Walk_____
Say first words_____	Speak in sentences_____	Show a preferred hand_____	Toilet train_____

Does your child receive any type of rehabilitative therapy?

Therapy	Days/Week	Home/School/Name of Center
Speech		
Occupational		
Physical		
Other, please list:		

Assistive Devices Which of these does your child use? (Please circle)

Wheelchair Gait Trainer Walker Standing Frame Stroller Bath Equipment

Upper Extremity Brace/Splint - Right, Left, Both – Day/Night

Lower Extremity Brace (AFOs, SMOs)-Right, Left, Both – Day/Night

Tone Management

Type	Outcome
Oral Medications	
Botox/Phenol Injections	
Casting	
Surgery	

Review of Systems Circle if your child has any of the following. If not, please circle "NO."

General	excess weight gain, excess weight loss, fatigue, sleep problems, fever	NO
Eyes	currently wears glasses, contact lens wearer	NO
Neck	a lump or swelling	NO
Cardiovascular	leg swelling, irregular heartbeat, faint feeling	NO
Respiratory	wheezing, cough, shortness of breath	NO
Gastrointestinal	decreased appetite, constipation, diarrhea	NO
Genitourinary	urine incontinence, pain during urination, urine odor	NO
Skin	rash, skin lesions, excessive body hair	NO
Neurological	difficulty swallowing, excessive drooling, seizures, tingling, numbness, headache	NO
Psychological	depressed, anxiety, behavior change	NO
Endocrine	change in urine volume: increase (polyuria)	NO
Hematologic	anemia, swollen glands, blood clot	NO
Allergic	seasonal allergies	NO