ONSLOW MEMORIAL HOSPITAL
Rehabilitation Services

PEDIATRIC PATIENT MEDICAL HISTORY

Child's Name: _____ Date of Birth: _____ Age:_____ Physician: _____

Parent/Caregiver/Legal Guardian: _____

Address: _____

Phone: (home) _____ (mobile)_____ (work)_____

Father's Name: _____ Age:_____Mother's Name: _____ Age: _____

Child's Siblings: How many?: _____ Age(s) of Siblings: _____

Concerns: / Reason for Seeking Therapy: _____

How do you hope therapy will help your child? _____

Prenatal/Birth History:

Mother's general health during pregnancy / labor (illness, accidents, medications, etc.): _____

Length of pregnancy (weeks gestation): _____ Length of labor: _____ Child's Weight: _____

Type of delivery: (circle): head first feet first caesarian Forceps? Y N Suction? Y N APGAR (if known) 1 min. _____ 5 min _____

NICU ? Y N Length of Admission: _____Name of NICU hospital: _____

Medical History:

Current Diagnoses_____Medical Tests or Procedures?:_____

Describe any major accidents/ injuries, illnesses, hospitalizations:_____

Medications: _____ Allergies?: _____Ear infections? _____How many?_____

Specialists who have seen your child: _____ Previous therapy?_____ Why stopped? _____

When? _____For how long?: _____ Type:_____

Does your child indicate he/she is in frequent pain? _____If so, where? _____Factors contributing to pain: _____

Is he/she in pain today? _____Please rate the pain: (0 is no pain; 5 is a trip to emergency room) 0 1 2 3 4 5

Has your child been diagnosed with any of the following illnesses or conditions? Please note at what age:

_____Erb's / Klumpke's Palsy	_____ Allergies	_____Asthma	_____ Ear Tubes
_____ Clubfoot Right Left	_____ Heart Problem	_____Convulsions	_____ Headaches
_____ Torticollis	_____ Down's Syn.	_____Eating Prob.	_____Head Injury
_____ Prematurity	_____ Encephalitis	_____ Cerebral Palsy	_____Reflux
_____ ROP	_____ High Fever	_____ Cold/Flu	_____ Sinusitis
_____ Sleeping Problems	_____ PDD / Autism	_____ Meningitis	_____ Other
_____ Muscular Dystrophy	_____ Pneumonia	_____ Tonsillitis	___Yes ___ No Hearing Loss
_____ Fractures	_____ Developmental	_____ Tumor?	
location? _____		location? _____	OTHER_____

List any medical tests or procedures your child has had: _____

Current Height: _____ Current Weight: _____ Vision screening? € Y € N Date:_____ Hearing Screening? € Y € N Date:_____

DEVELOPMENTAL HISTORY

Your child's age when able to: sit (unsupported) _____ crawl _____ stand (alone)_____ walk (without help) _____

talk (1-2 words) _____ Concerns? _____

EDUCATIONAL HISTORY /SCHOOL / DAY CARE

Name of School / Day Care:_____Telephone: _____

Attends: € Preschool € Daycare € Primary School

Frequency:_____

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CHILD'S NAME:_____

In your opinion, would the school/day care be willing to follow treatment for your child's difficulties? ____ Y ____N

Does your child receive 'Early childhood Intervention' services? Y N Type:_____ Does your child have? **IFSP** **IEP**

Provide a copy? Y N Therapy in public school? Y N Type: _____For:_____ Frequency of Service _____

Do you feel these services meet your child's needs? _____Reasons: _____

OBSERVATIONS : Please Check all that Apply

Motor Control and Planning:

- € did not crawl before able to walk
- € falls frequently (over 15 mos.)
- € fatigues easily during physical activities
- € trips over or bumps into obstacles
- € scared to try new motor activities
- € difficulty with small objects /fasteners
- € has loose grip on objects such as pencil / spoon OR grip is too tight
- € has difficulty with dressing and sequenced motor actions (skipping, buttoning, scissoring)

Speech and Language:

- € non-verbal/no words
- € sentences do not make sense
- € difficult to understand child's speech
- € bilingual Primary language:_____
- € cannot imitate words
- € off topic responses
- € has difficulty understanding others
- € repeats what others say
- € does not use sentences (over 3 years)
- € difficulty using grammar
- € has trouble with certain sounds
- € list sounds:_____

other language(s):_____

How does your child communicate (words, sentences, gestures): _____

***Play / Interactions and Self-Regulation*:**

- € difficulty transitioning - one activity to another
- € is easily frustrated, like to control activities
- € difficulty separating from, parents, sitter, etc
- € responds to discipline / limit-setting
- € has difficulty calming self
- € unable to interact back and forth with care-give
- € avoids eye contact; turns away from faces
- € prefers certain toys or objects
- € needs routine
- € unable to wait for food or toy without distress
- € must have control of environment
- € "runs the show"
- € unable to change from one activity to another without getting distressed

Sleep Patterns and Habits:

- € has difficulties going to sleep at naptime,
- € has difficulties staying asleep (restless),
- € tantrums when put to bed
- € other behaviors when put to bed
- € has difficulties going to sleep at bedtime,
- € has difficulties staying asleep (restless)

Sleep position:_____ Sleeps in: € bed/ crib € other_____

Naptime: _____am _____pm Wake Time: _____am Bedtime: _____pm

- € has difficulties staying in bed,
- € wants to sleep in caregiver's bed

Adaptive Behaviors: (please check all that apply)

- € walks without assistance
- € toilet trained
- € follows directions
- € hearing impaired
- € needs glasses/ visually impaired
- € uses words or signs to communicate
- € can imitate modeled words or behaviors

Supervisory Needs:

- € 1:1 supervision at all times
- € distant supervision or monitoring
- € can be left unattended for short time

Behavioral Concerns: (please check all that apply)

- € doesn't do what he/she is told
- € temper tantrums
- € hurts other people
- € throws things
- € is overactive
- € separation anxiety
- € does not interact
- € difficulties playing with others
- € eats non-edibles
- € bites nails
- € body rocking
- € thumb sucking
- € hand flapping
- € repeats what others say
- € insists on same way
- € difficult to understand
- € hurts self when frustrated
- € accident prone
- € difficulty paying attention
- € frequent complaints about:_____
- € potty trained but accidents at night
- € other:_____

Action taken at home for behavioral concerns: _____

Parent/ Caregiver Goals: _____

Signature / Date: _____

History Completed by: _____

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