PEDIATRIC OUTPATIENT MEDICAL HISTORY

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

Caregiver/Legal Guardian

Name: _____

Address: _____

_____

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

Mother's Name: _____ Age: ____ Occupation: _____ Child's Siblings How many?: _____

Age(s) of Child's Siblings: _____ Father's Name: _____ Age: ____ Occupation: _____

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 __suction? APGAR (if known)l min. ___ 5 min ___ NICU: Y N

Length of Admission: _____ Name of NICU hospital: _____ Notes: _____

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 ? _____

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: (zero 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	_____ Hearing Loss
_____ Fractures	_____ Developmental	_____ Tumor	
where? _____		where? _____	OTHER _____

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

Current Height: _____ Current Weight: _____ Vision screening? ____ Y ____ N When? _____

DEVELOPMENTAL HISTORY

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

talk (1-2 words) _____ Concerns? _____