

# Personalized Therapy, LLC

Occupational & Physical Therapy for Children & Adults

## PEDIATRIC HISTORY FORM

<b>Child Name:</b>	<b>Date of Birth:</b>
<b>Mother's Name:</b>	<b>Father's Name:</b>
<b>Address:</b>	
<b>Home Phone Number:</b>	
<b>Work Phone Number:</b>	
<b>Cell Phone Number:</b>	
<b>Email Address:</b>	

Please answer all of these questions to assist us in planning treatment for your child. All information is confidential as part of your child's medical record.

### Child's Primary Care Physician/Pediatrician

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone : \_\_\_\_\_

### Referring Physician (✓ if same as Primary/Pediatrician)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone : \_\_\_\_\_

### Pharmacy

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone : \_\_\_\_\_

### Educational/Cultural information

What language(s) is spoken at home?

What language are you most comfortable receiving information in?

What language is your child most comfortable receiving information in?

In what ways do you feel you would best be able to learn about your child's treatment?(*Check all that apply*)

- Demonstration       Instruction with Return Demonstration       Verbal Information  
 Written Information       Other: \_\_\_\_\_

5) Do you have any religious or cultural needs related to your child's care that we need to be aware of?  
I.e. diet, religious practices. (*If yes, please explain below*)      Yes       No

# Personalized Therapy, LLC

## Occupational & Physical Therapy for Children & Adults

### PEDIATRIC HISTORY FORM

#### Personal Characteristics Of School Age Children (If younger than 5, please proceed to next section)

Could be taken to public places without difficulty at ages 3, 4, 5? Yes  No

Hyperactive? Yes  No  Does child attend preschool? Yes  No

Any problems? Yes  No  Chores assigned? Yes  No

Needs reminders? Yes  No  Does chores without being asked? Yes  No

Gets ready for school in the morning without supervision? Yes  No

If yes, at what age? \_\_\_\_\_

Difficulty making friends? Yes  No  Difficulty keeping friends? Yes  No

Difficulty falling asleep? Yes  No  Difficulty staying asleep? Yes  No

Difficulty to awaken in morning? Yes  No  Takes naps? Yes  No

Snores? Yes  No  Needs an adult to be present for homework? Yes  No

Average time spent on homework: \_\_\_\_\_ Teacher suggested time for homework: \_\_\_\_\_

Please list all grades that were repeated: \_\_\_\_\_

Grade in which school difficulty first arose: \_\_\_\_\_

Does your child have any health problems that could impact on services? \_\_\_\_\_

Is there any significant family history that could impact on your child's services? \_\_\_\_\_

#### Birth History

During pregnancy, any high blood pressure, high blood sugar, infections? \_\_\_\_\_

Was your child born on time? Yes  No  If No, \_\_\_\_\_ weeks early/ \_\_\_\_\_ weeks late

Birth weight: \_\_\_\_\_ Age of mother at time of delivery: \_\_\_\_\_ Number of days in hospital \_\_\_\_\_

Colic? Yes  No  Circle one: Regular nursery **or** Intensive care nursery

#### Medical History

Allergies? Yes  No  If Yes, please list: \_\_\_\_\_

Does your child have a diagnosis? Yes  No  If Yes, please list: \_\_\_\_\_

Is your child currently on any medications? Yes  No  If Yes, please list: \_\_\_\_\_

Frequent ear infections? Yes  No  Tubes in ears? Yes  No

Tonsils/Adenoids removed? Yes  No  Ever unconscious? Yes  No

Head injuries/Concussions Yes  No  Fractures? Yes  No

Stitches? Yes  No

Age at each hospitalization: \_\_\_\_\_

Date of first seizure: \_\_\_\_\_

Has your child been involved in any serious accidents? Yes  No

Eyeglasses? Yes  No  Headaches? Yes  No

Any difficulty with hearing? Yes  No  Stomach aches? Yes  No

Starring spells? Yes  No  Pain? Yes  No

# Personalized Therapy, LLC

## Occupational & Physical Therapy for Children & Adults

### PEDIATRIC HISTORY FORM

Are your child's immunizations up to date? Yes  No  (If no, please explain) \_\_\_\_\_

Is your child being seen by any doctor/medical personnel other than a pediatrician/family practitioner? (please ✓ below)

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Neurosurgeon               | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Dentist           | <input type="checkbox"/> Neurologist            |
| <input type="checkbox"/> Psychologist/ Psychiatrist | <input type="checkbox"/> Rheumatologist     | <input type="checkbox"/> Ear Nose & Throat | <input type="checkbox"/> Occupational therapist |
| <input type="checkbox"/> Speech therapist           | <input type="checkbox"/> Other _____        |  |   |

**Developmental History** (please indicate the age at which your child did the following activities. If you don't recall, then please ✓ if it was completed within normal time frames):

- |  |   |   |
|--|---|---|
| _____ Roll over <input type="checkbox"/>                             | _____ First words <input type="checkbox"/>                            | _____ Toilet trained <input type="checkbox"/>                   |
| _____ Sit alone <input type="checkbox"/>                             | _____ Two word phrases <input type="checkbox"/>                       | _____ Button & zipper <input type="checkbox"/>                  |
| _____ Crawl <input type="checkbox"/>                                 | _____ Sentences <input type="checkbox"/>                              | _____ clothes <input type="checkbox"/>                          |
| _____ Walk alone <input type="checkbox"/>                            | _____ Ride a tricycle <input type="checkbox"/>                        | _____ Tie shoe laces <input type="checkbox"/>                   |
| _____ Alternate feet while ascending stairs <input type="checkbox"/> | _____ Ride a bicycle without training wheels <input type="checkbox"/> | _____ Accidents: bowel/urine day/night <input type="checkbox"/> |

**Therapy** (please list the start date and current frequency for the following if applicable):

Physical Therapy: \_\_\_\_\_ times per week      Occupational Therapy: \_\_\_\_\_ times per week

Speech Therapy: \_\_\_\_\_ times per week      Counseling: \_\_\_\_\_ times per month

**Evaluations** (please list the dates and results for the following if applicable):

- Child study team: \_\_\_\_\_ Does child attend resource room? Yes  No  Receive Basic skills? Yes  No
- EEG \_\_\_\_\_ CT Scan or MRI: \_\_\_\_\_
- Other evaluations: \_\_\_\_\_

**Family History**

Marital Status (circle one): Single      Married      Separated      Divorced      Widowed

**Mother:** Occupation \_\_\_\_\_

Does the mother have a history of any of the following:

- |                              |  |  |  |
|------------------------------|--|--|--|
| Seizure                      | Yes <input type="checkbox"/> No <input type="checkbox"/> | Headaches                              | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Speech problems in childhood | Yes <input type="checkbox"/> No <input type="checkbox"/> | Muscle weakness                        | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|                              |  | Learning problems/hyperactive behavior | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Reads for pleasure? Yes  No

Spelling difficulty? Yes  No

Highest grade completed in school: \_\_\_\_\_

Name of mother's parents, sister, brothers, nieces, and nephews with problems similar to your child:

\_\_\_\_\_

**Father:** Occupation \_\_\_\_\_

Does the father have a history of any of the following:

- |                              |  |                 |  |
|------------------------------|--|-----------------|--|
| Seizure                      | Yes <input type="checkbox"/> No <input type="checkbox"/> | Headaches       | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Speech problems in childhood | Yes <input type="checkbox"/> No <input type="checkbox"/> | Muscle weakness | Yes <input type="checkbox"/> No <input type="checkbox"/> |

# Personalized Therapy, LLC

Occupational & Physical Therapy for Children & Adults

## PEDIATRIC HISTORY FORM

Reads for pleasure? Yes  No  Learning problems/hyperactive behavior Yes  No   
Spelling difficulty? Yes  No  Highest grade completed in school: \_\_\_\_\_  
Name of mother's parents, sister, brothers, nieces, and nephews with problems similar to your child:  
\_\_\_\_\_  
\_\_\_\_\_

Does any one in the household(s) smoke? Yes  No

**Siblings** (please list your child's siblings):

	Name	Age	Medications	School/grade
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

### Social History

Where does your child live:  House  Apartment  other: \_\_\_\_\_

Please list below the names and ages of individuals living in the household:

Name	Age
_____	_____
_____	_____
_____	_____

Who is the primary care giver for your child? \_\_\_\_\_

Does the place where your child lives have any of the following (check all that apply)

Elevator  Ramp  Stairs, no rail  Stairs, Rail  Other Obstacles: \_\_\_\_\_

Does your child utilize any of the following specialized equipment? (Check all that apply)

Bath Chair  Cane  Crutches  Glasses  Hearing Aid  Stander  
 Walker  Specialized Stroller  Wheelchair: Manual or Power  
 Other: \_\_\_\_\_

Is your child involved in any community activities (If yes, please list below). Yes  No

Clubs: \_\_\_\_\_  
 Sports: \_\_\_\_\_  
 Other: \_\_\_\_\_

Does your child receive any special services (If yes, please list below). Yes  No

\_\_\_\_\_  
\_\_\_\_\_

Does your child use a car/booster seat? (for children under 80 lbs.) Yes  No

# Personalized Therapy, LLC

Occupational & Physical Therapy for Children & Adults

## PEDIATRIC HISTORY FORM

Does your child use a seatbelt (for children over 80 lbs.)

Yes  No

### Educational History

1) What school does your child attend? \_\_\_\_\_  Regular Education  Special Education

2) What grade is your child in? \_\_\_\_\_

3) Does your child receive any services in school? (*If yes, please list below*). Yes  No

Occupational Therapy  Physical Therapy  Speech Therapy  Other: \_\_\_\_\_

4) Does your child have any difficulty performing age appropriate activities listed below? (*Check all that apply*)

- Bathing
- Climbing Stairs
- Communicating
- Dressing
- Feeding Themselves

- Reaching
- Running
- Sitting
- Sleeping
- Social Interacting

- Toileting
- Using Utensils
- Walking

X \_\_\_\_\_

Parent Signature

\_\_\_\_\_

Date