

Personalized Therapy, LLC

Occupational & Physical Therapy for Children & Adults

PEDIATRIC HISTORY FORM

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

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

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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

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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"/> |

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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

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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