



PEDIATRIC MEDICAL DATABASE

Person filling out this form: _____ Relationship to child: _____

Identifying Information

Client Name: _____ Date of Birth: _____ Age: _____ Gender: F M
Parent/Guardian Name(s): _____ Today's Date: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____
Address: _____ Town: _____ Zip: _____
Primary Physician: _____ Primary Physician Phone Number: _____
Referring Physician: _____ Referring Physician Phone Number: _____
Medical Diagnosis: _____

History of the Problem

What are you seeking therapy for? Please describe the present problem:

Have there been any changes to the present problem over time? Y N If yes, please explain:

What is your child's reaction to the problem?

How does the family react to the problem?

Medical History

Medical History (including accidents, surgeries etc.):

Previous medical/therapeutic assessments? Y N If yes, please describe below (include where and when):

Precautions to therapy (previous fractures, previous surgeries, seizures) and **ALLERGIES**: _____

Current/Past Medications: _____
Prescribing Physician: _____

Prenatal and Developmental History

Length of pregnancy _____ Type of Delivery _____

Difficulties during pregnancy/labor/delivery: Y N If yes, please explain:

Were drugs and/or alcohol used during the pregnancy? Y N If yes, please explain:

Birth weight: _____pounds _____ounces

Has your child had ear infections? Y N If yes, when: _____

Has hearing been formally tested? Y N

If yes, when was testing completed? _____

If yes, where was testing completed? _____

What were the results? _____

Were tubes placed? Y N If yes, when, where and by whom? _____

Any vision difficulties? Y N If yes, please explain: _____

Does your child wear glasses? Y N

If yes, state reason _____

Developmental milestones (please list age which milestone occurred):

Roll _____ Crawl _____ Sit Unsupported _____ Walk _____ Babble _____

Say First Word _____ Speak in Sentences _____

Attention span for self-directed activities? _____

Attention span for adult-directed activities? _____

What types of food does your child eat? _____

Does your child feed him/herself? Y N

Does your child dress/groom him/herself? Y N

Is your child toilet trained during the daytime? Y N Nighttime: Y N

Is your child currently receiving, or has your child received any services in the past? If yes, please describe:

➤ Birth to Three Services: _____

➤ School Based Therapy: _____

➤ Outpatient Specialist Evaluation/Treatment: _____

Social and School History

What languages are spoken at home? _____

Please describe the family members your child lives with (siblings, parents, grandparents, pets, etc.): _____

Please describe your child's day care, educational and/or play settings: _____

Does your child exhibit any academic difficulties? Does your child have an IEP? _____

What are your child's favorite toys, hobbies, interests, etc.? _____

Does your child have any behavioral problems? _____

What strategies have you found effective for behavioral management? _____

What are your family's goals for therapy? _____

Is there any additional information that would assist us in providing care to your child (likes, dislikes)?

Where and with whom should we share/send this report?

Emergency Contact: List someone other than the person who regularly brings your child to therapy:

Name: _____ Relationship to Client: _____ Phone: _____

Thank you for completing this form as it will greatly enhance your child's evaluation process! We look forward to working with you and your child!