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)?
____
____

<u>Emergency Contact:</u> **<u>List someone other than the person who regularly brings your child to therapy:</u>**

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!