



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. Please return it to CFZ prior to evaluation via email, fax, or mail to give the evaluating therapist ample time to review your child's information.

We look forward to working with you and your child!

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