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)?
____
____

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

Name: ____________________________ Relationship to Client: ______________________ Phone:______________

A copy of your child's evaluation will be sent to his/her referring physician and pediatrician. Additional copies of the evaluation will be provided upon request.

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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