Bacharach
INSTITUTE FOR REHABILITATION

PEDIATRIC MEDICAL HISTORY FORM

Patient: ______________________________________

DOB: _____________

Patient Identification

Eval. Date: _______________

Diagnosis: __________________________________

BORN: ____ **Full term** ____ **Premature (____) weeks** ____ **Single** ____ **Twin** ____ **Multiple**
____ **C-Section** ____ **Vaginal** ____ **forceps** ____ **Breech**

HISTORY OF CURRENT PROBLEM

The condition child is starting or continuing therapy for was a result of:

____Vehicle Accident
___ Athletic Activity
___ Repetitive Motion/Overuse
___ Gradual Onset
___ Birth/Pregnancy complication
___ Pulling/pushing/climbing
___ Other______________________________________
___ Fall
___ Lifting/Carrying
___ Sudden onset / No trauma
___ Genetic condition
___ Assault

1. When did the problem(s) begin? Date ___/____/____
2. Has your child ever had this problem/injury before?
 _____Yes _____No (go to Q6)
3. What did you do for the problem/injury?________________
 ____
4. Did the problem/injury get better? _____Yes _____No
5. What are you doing now to improve your child's problem/ injury?____
6. Has your child had therapy before today? ____Yes ___No
7. What are your main concerns for your child?
 a. ____
 b. ____

GENERAL DEVELOPMENT

1. Has your child reached age-appropriate milestones for development? _____________________________
2. Does your child participate in dressing him/herself? undressing? _________________________________
3. Is your child toilet trained?____________________
4. Does your child have any sleep disturbances? _____
5. Does your child appear clumsy (falling, bumping into things) compared to other children? _______________
6. Does your child have difficulty coloring, drawing, writing, or scissor-cutting?_____________________
7. Does your child have difficulty talking or having his/her speech understood?______________________

Bacharach can discuss my health information with the following people who are involved in my child's care:

____
____
____

WHERE DOES CHILD LIVE?

___ Private home ___1-story ___ 2-story
___ Private apartment ___1-story ___ 2-story
___ Other ____________________________

WITH WHOM DOES CHILD LIVE?

___ Parents
 Names: ____________________________
 Phone #: ___________________________
___ Other Guardians
 Names____________________________
 Phone #: ___________________________

Siblings: __________________________________
 ____

DOES HOME HAVE

___ Stairs, no railing How many? _______
___ Stairs, railing How many? _______
___ Steps to enter How many? _______
___ Ramps ___ Elevator ___ Uneven terrain
___ Other obstacles ___________________

DOES CHILD USE

___ Cane ___Crutches ___Walker/Rollator
___ Wheelchair: ___Manual ___ Motorized
___ Stander ___ Adapted feeding chair
____Other __________________________

CURRENT LIMITATIONS (Check all that apply.)

___ Floor mobility ___ crawling ___ rolling ___ sitting
___ Bed Mobility (change position in bed)
___ Transfers such as moving bed to chair, chair to commode
___ Gait (walking) __ on level __ on stairs __ on ramps
___ Difficulty with self-care (bathing, dressing, eating, toileting)
___ Difficulty with school / sport activities
 ___ Out of work/school
 ___ No participation in recreation or leisure activities
___ Lifting
___ Communication Problem
___ Decreased play skills
___ Age appropriate developmental skills

HAND DOMINANCE

___ Left ___Unknown ___ Right

For girls over 11: Are you pregnant, or think you might be pregnant? ____ Yes ____ No

Does child have a history of a resistant bacteria such as MRSA? Or, if hospitalized, did staff wear gowns and gloves each time they entered the room? ___Yes ___No

PEDIATRIC MEDICAL HISTORY FORM

Patient Identification

MEDICAL HISTORY ☐ **None**

___Arthritis
___Asthma/Lung Problem
___Blood disorders
___Broken bones/fracture
___Eating Problem
___Cancer
___Depression, Anxiety, Irritability
___Developmental or Growth Problems
___Diabetes/Low Blood Sugar
___Dizziness
___Digestive Problems
___Emotional/Behavioral problem
___Repeated Infections
___ Kidney problems
___ Headaches
___ Heart Problems
___ Hepatitis
___ Muscle/Bone Disease
___ Seizures/Epilepsy
___ Skin Infections
___ Substance Abuse
___ Thyroid Problems
___ Learning Disability
___ Vision/Hearing Problem
___ Weight – Over / Under
___ Bowel/Bladder problem
___ Balance Problem/Falls
___Other____

Please list child's current medications and their purposes (pain relief, arthritis, etc) taken**:**

MEDICATION	**PURPOSE**
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

List all other medications/purposes: (including over-the-counter medications, vitamins, and herbs)

______________________	______________________
______________________	______________________
______________________	______________________

Not taking any medication for this problem/injury? ☐

Within the past year, has child had any of the following symptoms? (Check all that apply) ☐ None

___ Back/Neck Pain
___ Bowel Problems
___ Chest Pain
___ Coordination Problem
___ Cough
___ Communication problem
___ Difficulty Sleeping
___ Difficulty Swallowing
___ Difficulty Walking
___ Dizziness/Blackouts
___ Fever/Chills/Sweats
___ Headaches
___ Heart Palpitations
___ Fall within last 3 months
___ Hearing Problems
___ Hoarseness
___ Joint Pain/Swelling
___ Loss of Appetite
___ Loss of Balance
___ Nausea/Vomiting
___ Pain at Night
___ Shortness of Breath
___ Urinary Problems
___ Vision Problems
___ Weakness/Arms/Legs
___ Weight Loss/Gain
___ Tripping
___ Frequent falls
___ Other ____

Within the past year, has child had any of the following medical tests? (Check all that child has had, and circle test(s) scheduled

___ MRI ☐ None
___ Blood Tests
___ X-rays
___ Other ____________________________________
____

ALLERGIES ☐ None
(Check if child ever had the following):
Allergies: ( ) Medication ( ) Food ( )Environmental ( )Latex
Please list all known allergies (attach separate sheet if needed)
____

Has child ever had surgery? ___ Yes ___ No
If yes, please list significant surgeries, and indicate dates:

________________________________	_____________
________________________________	_____________
________________________________	_____________
________________________________	_____________

EDUCATION/EMPLOYMENT
Is your child currently enrolled in school? _____________
Present grade?_________________
Does the reason your child needs therapy interfere with schoolwork or gym? ____________________________
Is your child currently enrolled in an Early Intervention Program or Individual Education Plan?_______________
____
Does your child receive special services in school or the community? (ex. Speech, resource room)_____________
____
Leisure interests:________________________________
Method your child learns best: __ Watching __Listening ___ Doing ___ Having written information

CULTURAL/RELIGIOUS: Are there spiritual needs or religious practices we need to be aware of?
____
☐ None

ABUSE SCREENING
Do you have any concerns about physical, emotional, or sexual abuse? ___No ___Yes
Would you like to talk to someone about your situation?
___No ___Yes

Please provide the following information: (all that apply)

Referring Physician ___________________________________ Pediatrician ____________________________________
Orthopedist ___________________________________ Neurologist ____________________________________
ENT ___________________________________ Gastroenterologist ________________________________
Developmental specialist ______________________________ Other_______________________________________

PARENT/GUARDIAN SIGNATURE: ______________________________ **DATE:** ____________ **TIME:**__________