Bacharach
INSTITUTE FOR REHABILITATION

FAMILY AND MEDICAL HISTORY FORM

PART 1 - GENERAL INFORMATION

CHILD'S FULL NAME: ________________________________ DATE OF BIRTH: ______________________

HOME ADDRESS: ____

HOME PHONE: ____

PHYSICIAN'S NAME: __________________________________ PHONE #: _________________________

PARENT INFORMATION/ PRIMARY CAREGIVERS

FATHER'S NAME: ___________________________________ DATE OF BIRTH: ______________________

PRIMARY LANGUAGE: _______________________________ OCCUPATION: ________________________

RELATIONSHIP TO CHILD (please circle one): Biological Adoptive Step Foster Other

MOTHER'S NAME: __________________________________ DATE OF BIRTH: ______________________

PRIMARY LANGUAGE: _______________________________ OCCUPATION: ________________________

RELATIONSHIP TO CHILD (please circle one): Biological Adoptive Step Foster Other

BIOLOGICAL PARENT INFORMATION (if not current caregiver or different from above):

FATHER'S/MOTHER'S NAME: _________________________ DATE OF BIRTH: ______________________

ADDRESS: ____

PHONE #: ____

ARE THERE ANY CUSTODY ISSUES YOUR THERAPIST NEEDS TO KNOW ABOUT?

____

IF BOTH PRIMARY CAREGIVERS WORK, WHO CARES FOR THE CHILD?

____

SCHEDULE ? ____

OTHER PERSONS LIVING IN THIS CHILD'S HOUSEHOLD:

NAME	SEX	AGE/GRADE	RELATIONSHIP TO CHILD

PART 2: PREGNANCY AND BIRTH HISTORY

1. Gestational Age at time of delivery (or # weeks early or late): ______________________________

2. Length of Labor (in hours)? ____________________

3. What type of delivery (please circle)? Vaginal Cesarean Section = elective or emergency

   Presentation: Head, Face, Breech, Transverse Reason for C-section ____________________

   Assistance: Forceps, Vacuum, other ______________________________

4. Did you experience any of the following problems during the labor/delivery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (why, what occurred, how treated etc):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			MATERNAL infection	
2			Low/high red/white blood cell count	
3			Pelvis or cervical problems	
4			Placenta problems	
5			Dysfunctional labor	
6			BABY had the cord around the neck	
7			Cord problems (knots, prolapsed, compression)	
8			Baby had very low or high heart rate	
9			Baby had heart rate decelerations	
10			Fetal distress was noted	
11			Meconium was noted	

5. What was the baby's Birth Weight? ______________ Birth Length ____________________

6. Number of Days spent in the nursery? ____________________NICU or Newborn Nursery? ______________

7. What was the condition of your infant while in the nursery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, what occurred, how treated etc):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Was blue/cyanotic at birth	
2			Required stimulation to breathe	
3			Required oxygen at birth	How much/what type?
4			Required resuscitation	
5			Was considered small for gestational age	
6			Had tremoring or seizures	Which/for how long?

7			Very low tone	
8			Brain hemorrhage	
9			Anemia and/or transfusions	Which/how many times?
10			Jaundice (yellow)	How much/how treated?
11			Had bruising	
12			Rh incompatibility problems	
13			Infections	
14			Congenital birth defects	
15			Aspiration (meconium or fluid)	Which/how treated?
16			Respiratory distress signs or syndrome	
17			Needed ventilation	What type/how long?
18			Choking or vomiting episodes	
19			Tube feedings	
20			Needed medications	

PART 3: MEDICAL HISTORY OF CHILD

Please mark if you child has had any of the following.

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Frequent Colds/Respiratory Illness	
2			Frequent Strep throat/sore throat	
3			Frequent Ear Infections (tubes)	
4			Birth defect/genetic disorder	
5			Lung condition/respiratory disorder	
6			Allergies or asthma	
7			Heart condition	
8			Anemia/blood disorder	
9			Kidney/Renal disorder	
10			Urinary problems/infections	
11			Hormonal problem	
12			Muscle disorder/muscle problem	
13			Joint or bone problems	
14			Fractured bones	
15			Skin disorder/skin problems (eczema)	
16			Visual disorder/vision problems	
17			Eye infections	
18			Neurological disorder	
19			Seizures or convulsions	
20			Stomach disorder/stomach pain	
21			Vomiting/digestion problems	
22			Failure to gain weight/feeding problems	
23			Constipation/diarrhea problems	
24			Dehydration episodes	
25			Hearing Loss/Ear disorder	

26			Significant accidents	
27			Head injuries or concussions	
28			Ingestion of toxins, poisons, foreign objects	
29			Major medical procedures (detail below)	
30			Chronic medications (for what? when?)	
31			Any major childhood illness (pox, croup, measles, mumps, meningitis etc)	

HOSPITALIZATIONS AND/OR SURGERIES:
List the dates of any hospitalizations your child has had and the reason. List the dates of any surgeries your child has had and the reasons.

1. ____ 3. ____

2. ____ 4. ____

PRESENT HEALTH STATUS: Most recent Height = ________ Weight = ___________Date: ________

Are vaccinations up to date? _______________ If not, why? ____

Please note any illnesses for which your child is currently being treated, including their Current Medications:_____

____

____

PART 4: DEVELOPMENTAL HISTORY

We would like to have information about your child's developmental milestones. Indicate the age when your child first did each of the following INDEPENDENTLY. If you can not recall/find a specific age, please mark whether you believe your child accomplished the milestone early, on time or late. If your child has not yet achieved the milestone, write NA in the age column. Please also rate your estimation of the quality of your child's skills.

MILESTONE	AGE	EARLY	ON TIME	LATE		GOOD/FAIR	POOR
Smiled							
Held head up							
Rolled over							
Reached for an object actively							
Transferred object between hands							
Sat unsupported							
Crawled							
Stood alone							
Walked by self							
Said first words							
Threw objects actively							
Ran by self							
Followed simple 1 step directions							
Said 2-3 phrases							
Ate unaided with a spoon/fork							
Dressed self							
Rode bicycle without training wheels							

Caught a thrown object							
Demonstrated handedness (which?)							
Knew colors							
Counted to 5							
Knew alphabet							
Bladder trained - days							
Bladder trained - nights							
Bowel trained							

Part 4: Developmental History (continued)

1. Do you feel your child was "faster" or "slower" than his/her peers in any other way? Please explain __________

____

2. If your child is in school, please describe any difficulties or strengths in reading, writing or spelling: __________

____

3. Name of previously attended school(s):__________________ Grades(s): __________________

__________________ __________________

4. Name of current school: __________________ Grade: __________________

Address: __________________ Phone: __________________

Any special educations services (which, when)?__________________

Teacher:__________________

Describe any other concerns shared by the teacher: __________________

____

5. Has your Child ever been in therapy (eg. Occupational Therapy, Speech Therapy, psychotherapy, Physical Therapy)? Please indicate what type and when, and who the provider was.

Start date – End date	Type of Therapy	Provider Name	Provider contact information

6. Has your child had problems with any of the following (beyond expected for child's age):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Sleeping problems	
2			Bed wetting	
3			Drooling	
4			Thumb sucking	
5			Temper tantrums	
6			Head banging	
7			Breath holding	
ITEM	NO	YES	DESCRIPTION	EXPLANATION
8			Aggression/destructiveness	
9			Nervous habits (nail biting etc)	
10			Fire play or cruelty to animals	
11			Major mood swings	
12			Under or over reactive to sounds	
13			Under or over reactive to clothing	
14			Under or over reactive to taste	
15			Under or over reactive to smell	
16			Any unusual fears?	