Child's Name: _____ Date: _____
Parent(s): _____ Child's birthdate: _____
Phone: Home/Cell: _____ Child's chronological age:____ ❑ Male ❑ Female
E-Mail: _____ Insurance: _____
Address (where child resides): _____
Referred by: _____ Pediatrician: _____
MD phone: _____ MD fax: _____

Please list your child's diagnosis (if there is one), doctor who diagnosed, and when the diagnosis was given:

_____

_____

Child is: Biological_____ Foster_____ Adopted_____ If so, at what age: _____

Pregnancy / Birth History

Length of pregnancy: _____ Problems during pregnancy? ❑ Yes ❑ No
If complications, please describe: _____

_____

Delivery: ❑ Normal ❑ Breech ❑ Caesarian ❑ Other: _____
Additional significant birth information (i.e., NICU admission, jaundice): _____

_____

❑ Serious illness or condition. Please list and describe _____
❑ Hospitalizations for illness or operations: _____
List current medications: _____

_____

_____

Developmental milestones (list ages):
Rolled:_____ Sat:_____ Crawled:_____ Walked:_____ First word:_____ Combined words:_____
Potty trained:_____ Dressed self:_____

Medical History

Does your child have any of the following?

Adenoidectomy?	❑ Yes ❑ No	Head Trauma?	❑ Yes ❑ No
Allergies/Chronic colds?	❑ Yes ❑ No	Hearing Impairment?	❑ Yes ❑ No
Attention Deficit Disorder?	❑ Yes ❑ No	Heart problems?	❑ Yes ❑ No
Behavior problems?	❑ Yes ❑ No	Orthopedic problems?	❑ Yes ❑ No
Cerebral Palsy?	❑ Yes ❑ No	Respiratory problems/Asthma?	❑ Yes ❑ No
Ear infections?	❑ Yes ❑ No	Seizures?	❑ Yes ❑ No
If ear infections, how many in last 12 months? _____		Sensory problems?	❑ Yes ❑ No
Ear tube placement?	❑ Yes ❑ No	Sleeping problems?	❑ Yes ❑ No
Feeding Problems?	❑ Yes ❑ No	Tonsillectomy?	❑ Yes ❑ No
Global Dev. delay?	❑ Yes ❑ No	Vision problems?	❑ Yes ❑ No

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7782-1005
(Rev. 3/17)

OUTPATIENT PEDIATRIC REHABILITATION PATIENT HISTORY AND PHYSICAL INTAKE FORM

Consulting Specialists: (Orthopedist/Neurologist/Psychologist):
Name: _____ Phone: _____
Name: _____ Phone: _____

Daycare, School, Therapy History

School: _____ Phone: _____
Days and Time: _____
Grade: _____

School based OT ❑ Yes ❑ No
PT ❑ Yes ❑ No
ST ❑ Yes ❑ No

Hope infant program	❑ Yes ❑ No	ABA	❑ Yes ❑ No
Regional center	❑ Yes ❑ No	Respite	❑ Yes ❑ No
CCS	❑ Yes ❑ No	EFMN	❑ Yes ❑ No

Wheelchair	❑ Yes ❑ No	Feeder chair	❑ Yes ❑ No	Adaptive Cup	❑ Yes ❑ No
Walker	❑ Yes ❑ No	Braces	❑ Yes ❑ No	Adaptive Utensil	❑ Yes ❑ No
Communication device	❑ Yes ❑ No	Orthotics	❑ Yes ❑ No	G-tube/PEG	❑ Yes ❑ No

Is your child currently (or in the past) receiving outpatient: ST ❑ Yes ❑ No
PT ❑ Yes ❑ No
OT ❑ Yes ❑ No

Please list reason for treatment:

_____
_____
_____

Has your child received a vision examination? ❑ Yes ❑ No Glasses ❑ Yes ❑ No
Has your child received a hearing examination? ❑ Yes ❑ No Hearing aids/cochlear implant ❑ Yes ❑ No
If so, where was the examination completed, and what were the results? _____
_____

Describe any behavioral concerns in classroom or at home: _____

By signing I declare that the information that I have provided in this form is correct and complete to the best of my knowledge.

Patient/Representative (Print Name)	Patient/Representative Initials	Date

OUTPATIENT PEDIATRIC REHABILITATION PATIENT HISTORY AND PHYSICAL INTAKE FORM

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