SPORTSCARE PHYSICAL THERAPY

# Pediatric Medical History

Child's Name: _____ Date of Birth: _____

Person Completing the Form: _____ Relation to child: _____

Pediatrician: _____

Phone number: _____

Referred by: _____

Other services child is receiving: _____

Reason for Referral:

_____

_____

When did you first notice your child's motor difficulty? _____

Describe any problems that appear to be the result of your child's difficulty: _____

_____

What is your goal for your child's therapy? _____

_____

_____

**Personal Information:**

Does the child live at home with both parents? ___ Yes or ___ No

If no, with whom does the child reside? _____

Who is responsible for making health care decisions for the child? _____

Primary language spoken at home: _____

Brother(s)/Sister(s)? _____

Education History:

Age at entrance to school: _____ years _____ months

Current School: _____ Grade: _____

Does your child have an IEP? ___ Yes or ___ No

Indicate any/all areas of difficulty (circle all that apply):

| | | | | |
|---|---|---|---|---|
| Reading | Math | Writing Sentences | Complex directions | Attention |
| Handwriting | Spelling | Organization | Study Habits | rhyming |

**Medical History:**

Approximate date of last medical examination: _____

Approximate date of last hearing examination: _____

Approximate date of last eye examination: _____

Please list any medication(s) your child is taking and the reason for the Medication: _____

_____

_____

Are immunizations up to date? _____ Yes or ____No

Is your child allergic to anything? _____ Yes or ____ No; if yes please list: _____

_____

Has your child experienced any of the following:

| Condition | Yes | No | Comments |
|---|---|---|---|
| Frequent ear infections | | | |
| Myringotomy/ PE tubes | | | |
| Hearing loss | | | |
| Asthma | | | |
| Head injury | | | |
| Hospitalizations | | | |
| Tonsillectomy | | | |
| Adenoidectomy | | | |
| Seizures | | | |
| Oral surgery | | | |
| Cleft palate | | | |
| Specified syndrome | | | |
| Cardiac issues | | | |
| Stroke | | | |
| Autism spectrum diagnosis | | | |
| Orthodontics | | | |
| Gastric reflux | | | |
| Facial surgery | | | |
| Difficulty sleeping | | | |
| Difficulty eating | | | |
| Reactions to immunizations | | | |
| Other (please specify) | | | |

**Pregnancy History:**

Were there any complications experienced during pregnancy, labor or delivery? If so please explain _____

_____

Was the mother exposed to or did she experience any of the following during pregnancy?

___ Rubella ___ Kidney Disease ___ Measles ___ Diabetes ___ High Blood Pressure ___ Bleeding

___ Thyroid Disease ___ Heart Disease ___ Toxemia ___ Preeclampsia

___ Other (please explain) _____

Birth History:

Birth Weight: _____ Which pregnancy was this child? _____

Patient was born at gestational age of _____ weeks.

Type of delivery: ____ Vaginal ____ C-Section

If vaginal delivery, was the baby: ____ Breech ____ Sideways ____ Face First

____ Forceps used ____ Vacuum extraction used

Were there any complications at birth? Please explain: _____

_____

_____

Did the child experience any of the following:

| | Yes | No | Comments |
|---|---|---|---|
| Insufficient oxygen | | | |
| Cry right away | | | |
| Jaundice | | | |
| Surgery | | | |
| Sucking or swallowing problems | | | |
| Need respirator | | | |
| Heart defect | | | |
| Seizures | | | |
| Infection | | | |
| Small for gestational age | | | |

Motor Development: List the age that your child achieved this skill:

| | Age | Comments |
|---|---|---|
| Smiled | | |
| Followed with eyes | | |
| Reached for objects | | |
| Rolled over | | |
| Sat without support | | |
| Crawled on belly | | |
| Crawled on hands and knees | | |
| Pulled to stand | | |
| Stood without support | | |
| Walked alone | | |
| Used the bathroom alone | | |
| Undressed self | | |
| Dressed self | | |
| Used buttons and snaps | | |
| Used zippers | | |
| Tied shoes | | |
| Skipped | | |
| Rode tricycle | | |
| Rode bicycle w/o training wheels | | |
| Used spoon and fork | | |
| Used writing tools | | |
| Used scissors | | |
| | | |

Does your child have difficulty in any of these areas:

___ dressing ___ rolling over ___ standing alone ___ handwriting

___ creeping on hands and knees ___ walking/running/jumping ___ bringing hands together at midline

___ zippers/buttons ___throwing a ball ___ building tower of blocks

___transferring objects from hand to hand ___ copying shapes ___ lifting head while on stomach

___ sitting alone ___ walking backwards ___ cutting on a line around a shape

___ balancing/hopping on one foot ___accepting weight onto legs

___ standing on furniture ___ walking up/down steps ___ hopping/jumping

___ lacing/tying shoes ___ bearing weight on arms ___ pulling to sit/stand

Behavioral History: Does your child:

| | Yes | No | Comments |
|---|---|---|---|
| Transition easily between tasks, places, etc. | | | |
| Fear strangers | | | |
| Cry excessively | | | |
| Engage in repetitive behaviors (rocking, flapping arms, etc.) | | | |
| Play appropriately with toys | | | |
| Play well with other children | | | |
| Respond to his/her name being called | | | |
| Respond to “no!” by ceasing activity/looking | | | |
| Avoid/cry when exposed to new sensations (loud noises, different textures) | | | |

Other physicians or therapists involved in your child’s care:

Name: _____ Specialty: _____

Address: _____ Phone: _____

Name: _____ Specialty: _____

Address: _____ Phone: _____

If there is any specific information which has not been requested on this form that you think would help us understand your child’s problem(s), please include here:

_____

_____

_____

_____

_____

Name Printed

_____ _____

Signature Date