


Northeast Rehabilitation Health Network
70 Butler Street
Salem, NH 03079
(603)893-2900 2 **Fax (603) 893-1628** **Form A**

Outpatient Pediatric Program(Pediatric and Children Services)
Developmental/Medical History Birth to 12 Years of Age

GENERAL INFORMATION

Child's Name: _____ Address: _____
Date of Birth: _____ Age: _____ _____
Parent's Names: _____ Phone: _____
Siblings Names and Ages:

Name	Age

SCHOOL HISTORY

School: _____ Grade: _____
Important School Related Information: _____
_____
_____
Does your child receive any services in school (i.e. therapy)? _____
If yes, please list the type and the amount of services
_____
_____

MEDICAL INFORMATION

Pediatrician's Name: _____ Address: _____
Phone Number: _____ _____
Referring Physician (name and address)_____
Medical Diagnosis (if any): _____
Please indicate the following:

			RESULTS/COMMENTS
Recent Vision Exam	YES	NO	
Wear Glasses	YES	NO	
Recent Hearing Exam	YES	NO	
Hearing Aids	YES	NO	
Immunizations Current	YES	NO	COPY ATTACHED? YES NO

If no, please explain: _____

PRENATAL HISTORY: **(mother's health during pregnancy)**

Did the mother have/take:			COMMENTS/SPECIFICS
Infections/illnesses during pregnancy?	YES	NO	
Unusual stresses during pregnancy?	YES	NO	
Any medication during pregnancy?	YES	NO	

BIRTH HISTORY

Full Term: YES NO Birth weight if full term: _____
Premature YES NO Birth weight if premature: _____ # of Weeks: _____
Cesarean Section: YES NO
Forceps used for delivery: YES NO
Breech (feet first): YES NO
Suction required for delivery: YES NO
Apgar scores if known: one minute: _____ five minutes: _____
Any complications with delivery:
YES NO
Did the child require any hospitalization? How Long?: _____
YES NO
If yes, please describe complications and/or hospitalization:

_____
_____
_____
_____

INFANCY AND EARLY CHILDHOOD

Did your child?			DESCRIBE
Have any feeding issues?	YES	NO	
Was difficult to comfort?	YES	NO	
Have trouble sleeping?	YES	NO	
Have colic?	YES	NO	
Have any positions he/she could not tolerate?(stomach, side etc.)	YES	NO	
Have a position of preference?	YES	NO	
Become "sick" from car rides or infant swings?	YES	NO	
Go through the "terrible two's" (if applicable)	YES	NO	

List any concerns that you had regarding your child during this period:

_____
_____
_____

MEDICAL HISTORY:

Has your child had any of the following? Please provide a brief explanation and approximate date of onset.

	YES	NO	ONSET DATE	DESCRIBE
Childhood Disease (i.e. chickenpox)	YES	NO		
Surgeries	YES	NO		
Seizures	YES	NO		
Cardiac Problems	YES	NO		
Respiratory Difficulties	YES	NO		
Congenital Abnormalities	YES	NO		
Casts/Braces	YES	NO		
Ear Infections	YES	NO		
Pain Issues	YES	NO		
Allergies	YES	NO	Circle all that apply	Environment/latex/food/insect
Current Medications	YES	NO	List Medication Allergies	List
Other:	YES	NO		

Are there any medical precautions that the evaluating therapist should be aware of?

_____

_____

_____

Has your child received any previous evaluations or treatment? YES NO

If yes, what type, when and what professional?

TYPE	DATE	TYPE AND PROFESSIONAL'S NAME	DATES OF TREATMENT

Please attach copies of previous evaluations to this history if you feel the information would be helpful to the treating therapist

DEVELOPMENTAL MILESTONES

Please list the approximate ages.

	Approximate Age
Rolling	
Sat Alone	
Crawled	
Walked	
Solid Foods	
Drank from a cup	
Said first word	
Said sentences	

Was the crawling phase brief?_____ Absent?: _____

Did the child use a walker? _____ How often? _____

Do you have religious, dietary or cultural needs that you would like us to be aware of? YES NO

If yes, explain _____

What information would you like to gain from this evaluation/treatment program?

_____

_____

_____

_____

_____

What goals would you like to see your child achieve?

_____

_____

_____

_____

_____

Other pertinent information or family history:

_____

_____

_____

_____

_____

_____ Date: _____

Signature of person completing this form

_____ Date: _____

Reviewed by Therapist