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

Pediatric Program(Adolescent Services)
Developmental/Medical History 13 - 18 Years of Age

GENERAL INFORMATION

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

Siblings Name	Age	Siblings 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: _____

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		
Cardiac Problems	YES	NO		

Respiratory Difficulties	YES	NO		
Congenital Abnormalities	YES	NO		
Casts/Braces	YES	NO		
Pain Issues	YES	NO		
Seizures	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 therapy evaluations or treatment? YES NO

If yes, what type, when and what professional?

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

_____

_____

_____

PRENATAL AND BIRTH HISTORY:

Were there any infections, illnesses or unusual stresses during pregnancy/delivery? YES NO

i.e. use of forceps, cesarean section, premature. COMMENTS

_____

_____

DEVELOPMENTAL MILESTONES OF INFANCY AND CHILDHOOD

Did the patient achieve sitting, walking, running, coordination within the typically expected time frame?

YES NO

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

If yes, explain _____

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

_____

_____

_____

What information or goals would you like to see your child achieve from this evaluation/treatment program?

_____

_____

_____

_____ Date: _____

Signature of person completing this form

_____ Date: _____

Reviewed by Therapist

Form revision 05/00