Northeast Rehabilitation Health Network
Outpatient Pediatric Program
Developmental / Medical History Birth – 18 Years of Age

Rev 9/17

Child Name: _____ Male ☐ Female ☐ Date of birth: _____
Name of Person Completing this Form: _____ Relationship: _____
Parent's Name: _____
Siblings: Yes ☐ No ☐ If yes, Names : _____
Preferred Language: _____
Reason for referral for therapy: _____
Parent or Caregiver concerns: _____

_____
What goals would you like to see your child achieve in therapy? _____

_____

BIRTH HISTORY

Difficulties during pregnancy: Yes ☐ No ☐ If yes please explain: _____

_____
Difficulties during delivery: Yes ☐ No ☐ If yes please explain: _____

_____
Delivery type: Vaginal ☐ or C-section ☐ Vacuum or forceps assisted: Yes ☐ No ☐
Gestational Age: Full term ☐ or Premature ☐ If premature, born at _____ weeks
Did child require any hospitalization? Yes ☐ No ☐ If yes, how long? _____
Apgar Score (if known): _____
Did child have any problems with the areas below? Please check all that apply:
☐ Jaundice ☐ Colic ☐ Feeding Problems ☐ Reflux ☐ Head Shape /tilt ☐ Sleeping

HEALTH HISTORY

Height: _____ Weight: _____
Does child have any allergies? Yes ☐ No ☐ If yes please list: _____

_____
Does child have a diagnosis? Yes ☐ No ☐ If yes please list: _____

_____
Is the child on any medications? Yes ☐ No ☐ If yes please list:

Medication	Dose/Frequency	Reason

Has the child ever had a seizure? Yes ☐ No ☐
Has the child had a head injury, concussion, fracture or stitches? Yes ☐ No ☐ If yes please explain:

_____

Has the child ever been hospitalized? Yes □ No □ If yes, please explain and provide date of hospitalization:

_____

_____

Has the child had any special test performed?

□ X-Ray □ MRI □ CT Scan □ MBS □ Other: _____

Has the child ever had any surgeries? Please list and provide date:

_____

_____

Has the child had a history of or currently experiencing any of the following conditions?

□ Seizures □ High Blood Pressure □ Osteopenia/Osteoarthritis □ Asthma □ Hepatitis
□ Low Blood Pressure □ Scoliosis □ Cancer: (type) _____ □ Heart Murmur
□ Hip Dysplasia □ Stroke: (what age) _____ □ Diabetes □ Rheumatoid Arthritis
□ Other: _____

Does the child have any of the following? Please check all that apply:

□ Tracheostomy □ Hearing Aids □ Hearing difficulties □ Glasses: _____
□ Latex sensitivity □ G- tube □ Colostomy □ Central Line □ Oxygen □ Respiratory Limitations
□ Weight bearing status: _____ □ Other or comments: _____

Does the child have any equipment? Please check all that apply:

	Type	Date Received
Wheelchair		
Gait Trainer		
Stander		
Bath Chair		
Seating Devices		
Other		

Vendor Name/Company: _____

Does the child have any orthotics? Please list all and date received:

	Type	Date Received
Upper Extremity		
Lower Extremity		
Trunk		
Helmet		

Orthotist's Name/Company: _____

MEDICAL PERSONNAL

Child's Pediatrician: _____ Phone: _____

Has the child been seen by any doctor/medical personnel other than a pediatrician/ family practitioner?
Please check all that apply and list name if know:

□ Neurologist: _____
□ Orthopedic: _____
□ Behaviorist: _____
□ Gastroenterologist: _____
□ Physiatrist: _____
□ Psychologist/Psychiatrist: _____
□ Ear Nose & Throat: _____
□ Optometrist/Ophthalmologist: _____
□ Occupational Therapist: _____
□ Physical Therapist: _____
□ Audiologist: _____
□ Speech Therapist: _____

□ Feeding Therapist: _____ □ Developmental Pediatrician: _____
□ ABA Therapy: _____ □ Other: _____

SCHOOL

Has the child received Early Intervention Services? Yes □ No □
If yes, what is the name of EI Provider and what services are provided? _____
_____

Has the child attended school? Yes □ No □ If yes, what is the name of school: _____
□ Regular Education □ Special Education Grade: _____

Does the child receive any services at school? Yes □ No □ If yes, please check all that apply below:
□ Occupational Therapy: _____ times per week
□ Physical Therapy: _____ times per week
□ Speech Therapy: _____ times per week
□ Other: _____

Thank you for the information you have provided us!

_____ _____ _____
Parent/Guardian Signature Date Time

Clinician's Only:

1. Medical History Reviewed with Caregiver □ Yes
2. Screen Completed □ Yes

**For Adult Clinics, please add BMI and Developmental Skills to WebPT Eval templates.

_____ _____ _____
Clinician Signature Date Time