Dignity Health
Pediatric Therapy
in partnership with Select Medical

Pediatric Medical History Form

Patient's Name: _____ Account #: _____

Date of Birth: _____ Chronological Age: ____ Adjusted Age: _____ (if applicable)

Parent/Guardian: _____ Referred by _____ Phone # _____

Reason for referral: _____

Parent Concerns/ Goals for Therapy: _____

Formal Diagnosis: _____

Prenatal History:

While pregnant, did mom have any complications? (Etc. high blood pressure, gestational diabetes, illness). ○ Yes ◉ No If yes, please explain _____

Birth History:

Born at 38-40 weeks' gestation: ◉ Yes ◉ No If no, born at weeks' gestation	
Birth weight:	NICU Stay: ○ Yes ◉ No If yes, # of days
Complications after birth: ◉ Yes ◉ No If yes, please explain	
Type of delivery: ☐ Vaginal ☐ Caesarian ☐ Breech(feet first) ☐ Forceps ☐ Adoption	
Passed Hearing Screening: ◉ Yes ◉ No	Passed Vision Screening: ◉ Yes ◉ No

Medical History: Has your child had any of the following: **(check all that apply)**

☐	Asthma or Chronic lung disease	☐	Blood Transfusion
☐	Blood: anemia (iron deficiency)	☐	Brain Bleed (IVH) Grade level:
☐	Bronchitis/Bronchiolitis	☐	Cancer
☐	Chicken pox	☐	Diabetes: ☐ Type I ☐ Type II
☐	Fractures/Broken bones:	☐	Head Injury
☐	Heart Problems	☐	Kidney problems
☐	Measles	☐	Meningitis
☐	Mumps	☐	Recurring ear infections
☐	Reflux	☐	Seizures

COVID-19: Has your child or immediate family had COVID-19? ◉ YES ◉ NO

If yes who and when: _____

Allergies:

_____

_____

_____

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Patient Name: _____ Account #: _____

Surgical History: Check any past surgeries, list age/date of surgery and name of surgeon if known

	Procedure	Age / Date of Surgery	Name of Surgeon
☐	Adenoidectomy (adenoids)		
☐	Ear Tubes		
☐	G-tube/ Mic-Key Button		
☐	Heart Surgery		
☐	Hernia Repair		
☐	Nissen Fundoplication		
☐	Orthopedic Surgery		
☐	Tonsillectomy (tonsils)		
☐	Urological Surgery		
☐	VP Shunt		
☐	Other surgeries		

Tests Performed: ☐ X-rays ☐ MRI ☐ CT Scan ☐ Genetic Testing

Results:_____

Medications: Please list all medications your child is taking (over the counter and prescription)

Name of medication	Dosage and Frequency	Reason for medication

Review of Systems: Does your child have or are you concerned about: (Please check Yes or No and comment if needed)

1.	Eyes	Yes	No	Comments
	Any visual problem?	○	○	
	Do eyes ever look crossed?	○	○	
	Does child wear glasses?	○	○	

2.	Ears	Yes	No	Comments
	Any hearing problems?	○	○	
	Has child had 3 or more ear infections?	○	○	

3.	**Heart,** have you been told your child has	Yes	No	Comments
	Heart murmur	○	○	
	Heart defect	○	○	
	High blood pressure	○	○	

4.	**Lungs**, have you been told your child has/has	Yes	No	Comments
	Asthma	○	○	
	Pneumonia	○	○	
	RSV	○	○	

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5.	Abdomen	Yes	No	Comments
	Constipation often	○	○	
	Diarrhea often	○	○	
	Difficulty with eating/appetite	○	○	
	Spit up/vomiting after eating	○	○	
	Unexplained weight loss or gain	○	○	

6.	Skin	Yes	No	Comments
	Eczema or Dermatitis	○	○	
	Sensitivity or allergy to latex	○	○	
	Moles, birthmarks, hemangiomas	○	○	

7.	Extremities	Yes	No	Comments
	Weakness or paralysis in arms/legs	○	○	
	Limp or awkward walking	○	○	
	Wears or worn or has braces for feet	○	○	

8.	Neurological	Yes	No	Comments
	Holds breath (if yes, when)	○	○	
	Seizures or tics	○	○	
	Body or arms/legs feel still	○	○	
	Body or arms/legs feel floppy	○	○	
	Arches or pushes backwards often	○	○	

Developmental history. Check all that apply and state an approximate age that your child achieved the following milestones:

9.	Gross Motor Development				
☐	Lifted head while on belly	Age:	☐	Rolled belly to back	Age:
☐	Rolled back to belly	Age:	☐	Sat when placed	Age:
☐	Crawled	Age:	☐	Got self to sitting	Age:
☐	Pull to stand	Age:	☐	Stood alone	Age:
☐	Walked alone	Age:	☐	Ran	Age:
☐	Jumped	Age:	☐	Walks up/down stairs	Age:

10.	Self Help and Activities of Daily Living				
☐	Holds bottle independently	Age:	☐	Finger feeds food	Age:
☐	Undresses self	Age:	☐	Dresses self	Age:
☐	Toilet trained	Age:	☐	Colors with crayons	Age:

11.	Speech / Social Skills				
☐	Socially Smiles	Age:	☐	Babbles: (mama, dada, etc.)	Age:
☐	Said first 5-10 words	Age:	☐	2-3 word sentence (I want, etc.)	Age:
☐	Turns when name is called	Age:			Age:

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Patient Name: _____ Account #: _____

12.	**Feeding Skills -** Does your child have any difficulties with the following:	**Yes**	**No**	**Comments**
	Swallowing foods:	○	○	
	Chewing foods:	○	○	
	Gags / chokes while eating	○	○	
	Uses spoon / fork	○	○	
	Drinks from open cup	○	○	
Please list any feeding concerns:				

13.	**Sensory History** – Does your child have any difficulties with the following:	**Yes**	**No**	**Comments**
	Overly sensitive if feet are touched	○	○	
	Overly sensitive if hands are touched	○	○	
	Hesitant / refuses to eat solid food	○	○	
	Hesitant / refusess teeth brushing	○	○	
	Hesitant / refuses hair brushing	○	○	
	Hesitant / refuses to be on swing	○	○	
	Hesitant or avoids getting messy	○	○	
	Impulsive?	○	○	
	Has poor safety awareness?	○	○	
	Overactive?	○	○	
	Aware of environment (i.e.; pays attention to obstacles)	○	○	
	Is clumsy and tends to trip / fall often	○	○	

14.	**Languages** spoken in the home, please list any additional languages spoken in the home:

Has your child previously received therapy?		**Yes**	**No**	**Comments -if yes, where**
	Physical Therapy	○	○	
	Occupational Therapy	○	○	
	Speech Therapy	○	○	

Please list all of the doctors that follows your child:

Dr. Name	Discipline (PCP, cardiologist, etc.)	Phone number	Next scheduled visit

Thank you for taking the time to complete this form so we may better get to know your child!

To the best of my knowledge, all of the above answers are true and correct. If ever there will be any changes in my child's health, or if his/her medications change, I will inform the treating therapist at the next appointment.

Signature of Parent/Guardian:_____Date: _____

Signature of Therapist:_____Date:_____