



PEDIATRIC MEDICAL HISTORY

Patient Name: _____

Date of birth: _____

PRIMARY CONCERNS

Please provide details of your primary concerns for the child that you would like to address in therapy:

PREGNANCY

Do you know the details of the pregnancy? ☐ Yes ☐ No

Pregnancy Proceeded: ☐ Normally ☐ With Complications

Prenatal Care was: ☐ Received ☐ Not Received Length of Pregnancy (in weeks): _____

Pregnancy Complications:

☐ Eclampsia	☐ Positive for Herpes	☐ Premature Labor
☐ Gestational Diabetes	☐ Positive for HIV	☐ Substance Exposure
☐ Multiple Births	☐ Positive for Strep B	☐ Toxemia
☐ Polyhydramnios	☐ Pre-Eclampsia	☐ Positive for Cytomegalovirus (CMV)
☐ Other: _____		

Please add any other comments regarding pregnancy: _____

DELIVERY

Do you know the details of the delivery? ☐ Yes ☐ No

Delivery Proceeded: ☐ Normally ☐ With Complications

Delivery was: ☐ Vaginal ☐ Cesarean ☐ Emergency Cesarean

Delivery Complications

☐ Abruptio placenta	☐ Premature Rupture of Membranes
☐ Breech Presentation	☐ Transverse Presentation
☐ Low Birth Weight	☐ Prolapsed Cord
☐ Negative Vacuum	☐ Use of Forceps
☐ Non-Progressive/Unproductive Labor	☐ Uterine Rupture
☐ Occiput Posterior Position (face up)	☐ Umbilical Cord around the neck
☐ Placenta Previa	☐ Other _____

Birth information

Mother's age at time of birth: _____ Years Birth Hospital: _____

Needed to be transferred to another hospital: ____ Yes ____ No Transfer Hospital: _____

Birth Weight: _____ Pounds _____ Ounces Birth Height: _____ Inches

Apgar Scores: ____ 1 min ____ 5 Min ____ 10 Min

Please indicate for this pregnancy:

Were there multiple children born from this pregnancy: ____ Yes ____ No

Number of live births: ____ Number of live births ____ Number of still births

Additional details of birth: _____

FOLLOWING BIRTH

Were there any complications following birth? ____ Yes ____ No

Length of child's hospital stay: _____

Complications following birth:

Anemia of Prematurity	IVH Bleed Grade I	PDA
Bronchopulmonary Dysplasia (BPD)	IVH Bleed Grade II	Positive Dependency
Cleft Lip	IVH Bleed Grade III	Respiratory Distress Syndrome
Cleft Palate	IVH Bleed Grade IV	Respiratory Stridor
Club Foot	Jaundice treated by light therapy	Respiratory Syncytial Virus (RSV)
Cytomegalovirus	Meconium Aspiration	Retinopathy of Prematurity (ROP)
ECMO	Necrotizing Enterocolitis	Thrombocytopenia (low platelet count)
Failure to Thrive	Neonatal Hypoxia	Ventilator Dependency
Hyperbilirubinemia	Oxygen Dependency	VP Shunt
Intrauterine Growth Retardation	Other:	

Please list any other complications or details: _____

Please list any syndromes that have either been diagnosed or are suspected: _____

MEDICATIONS, VITAMINS, & SUPPLEMENTS

Does this child take any medications: ____ Yes ____ No

If yes, please list the current medications including homeopathic supplements, vitamins, minerals, and other over the counter medications.

NAME OF MEDICATION	DOSE	FREQUENCY	METHOD

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Comments: _____

ALLERGIES

Does the child have any allergies: ☐ Yes ☐ No

ALLERGEN	TYPE	SEVERITY	ONSET DATE

Comments: _____

HEARING

Do you have concerns about the child's hearing? ☐ Yes ☐ No

☐ Never tested, Have no concerns ☐ Never tested, Have concerns

☐ Normal Test Results ☐ Abnormal Test Results

Results: _____

Concerns: _____

VISION

Do you have concerns about the child's vision?

☐ Never tested, Have no concerns ☐ Never tested, Have concerns

☐ Normal Test Results ☐ Abnormal Test Results

Results: _____

Concerns: _____

SURGERIES & PROCEDURES

Has the child had any surgeries or procedures? ☐ Yes ☐ No

SURGERY TYPE	DATE OF SURGERY

SURGERY TYPE	DATE OF SURGERY

DIAGNOSTIC TESTS

Has the child had any diagnostic tests? ☐ Yes ☐ No

TEST	WHEN	DETAILS/RESULTS (If Known)

CURRENT PHYSICIANS

Does the child see a physician regularly? ☐ Yes ☐ No

NAME	SPECIALITY	REASON	DATE OF LAST VISIT

MEDICAL CONDITIONS

Does the child have any medical conditions? ☐ Yes ☐ No

Does the child have:

☐	Allergies	☐	Constipation	☐	Seizure Condition
☐	Arteriovenous Malformation (AVM)	☐	Diarrhea	☐	Sleep Disorder
☐	Anoxic Brain Injury	☐	Down Syndrome	☐	Sleep Problems
☐	Asthma/Respiratory (breathing issues)	☐	Hip Subluxation – Degrees?	☐	Shunts
☐	Autism	☐	Hydrocele	☐	Torticollis
☐	Baclofen Pump	☐	Laryngomalacia	☐	Traumatic Brain Injury (TBI)
☐	Cerebral Palsy (CP)	☐	Muscular Dystrophy	☐	Tube Feeding
☐	Cerebral Vascular Accident (CVA)	☐	Osteoporosis	☐	Tubes in ears
☐	Chronic Ear Infections	☐	Periventricular Leukomalacia	☐	Vagal Nerve Stimulator
☐	Colic	☐	Reflux	☐	Scoliosis – Degrees?

Please list any other current medical conditions: _____

MOTOR DEVELOPMENT

Do you have concerns about the child's motor development? ☐ Yes ☐ No

Please indicate when the child's ability for reach activity approximately began

ACTIVITY	BEGAN AT AGE (IN MONTHS):	UNSURE	HAS NOT BEGUN
Bringing both hands to mouth			
Buttoning pants/shirt			
Come to sitting from laying without assistance			
Creeping or crawling alone			
Fully toilet trained			
Grabbing a toy			
Holding head up alone			
Pulling self to standing position			
Rolling over			
Self-bathing			
Self-dressing			
Sitting alone without support			
Standing unsupported			
Tying shoes			
Walking with support			
Walkin unaided			
Zippping/unzipping jacket			

HANDWRITING

Is your child: ☐ Left-Handed ☐ Right-Handed ☐ No Preference

Are there concerns about handwriting? ☐ Yes ☐ No If yes, please describe: _____

PLAY

What are the child's favorite toys for play activities? _____

How does the child primarily move around the home? _____

SENSORY PROCESSING/REGULATION

Select all that apply:

☐	Avoids getting messy	☐	Resists certain movements (e.g. bouncing, swinging, upside down)
☐	Seeks out (craves) touch or movement	☐	Has difficulty figuring out how to move body or takes more time with movements
☐	Stumbles or falls frequently	☐	Does not tolerate certain textures
☐	Appears awkward or less coordinated	☐	Uses a lot of pressure when touching someone or holding object
☐	Flaps hands	☐	Has difficulty transitioning from one activity to another

Resists/does not allow brushing of teeth		Has difficulty transitioning from one activity to another
Resists/does not allow brushing of teeth		Has difficulty falling asleep
Bangs on surface, bangs/hits head		Has difficulty remaining asleep through the night
Fatigues quickly		Appears lethargic/sleepy all the time
Has self-injurious behaviors		Has poor sense of body in space, runs into things
Resists certain tasks or environments		Seeks support for posture (e.g. leans on furniture, walls or people, holds head)
Spins things or self		Demonstrates stiff or rigid movement patterns
Is sensitive to lights, sounds, or noise		Hyper focused (on specific tasks, people, objects, etc.)
Sleeps a lot		Resists touch
Walks on Toes		Lines up toys or objects
Seeks out visually stimulating objects		Seeks out (craves) stimulating sounds
Other:		

SOCIAL/EMOTIONAL SKILLS

Select all that apply:

Is easily distracted		Prone to emotional outburst		Only plays with adults
Calms self easily		Doesn't allow others to join in play		Prefers to play alone
Gets angry/frustrated easily		Has difficulty making friends		Has difficulty with separations
Is aggressive towards others		Plays with peers		Has poor eye contact
Other: (Please describe)				

Description of Child (select all that apply):

Active		Affectionate		Aggressive		Calm		Cautious
Curious		Demanding		Difficult to comfort		Distractible		Fearful
Fearless		Fussy		Insecure		Motivated		Passive
Persistent		Playful		Shy		Stubborn		Withdrawn
Other: (Please describe)								

FEEDING & DIET

Do you have concerns about the child's feeding or diet? ____ Yes ____ No

Does the child currently use any feeding adaptations? ____ Yes ____ No

FEEDING MILESTONES

When did the child begin?	Age (in months)	Milestone	Age (in months)
Using a bottle		Stop using a bottle	
Using a pacifier		Stop using pacifier	
Eating baby food		Using utensils to eat	

Eating table food		Holding own bottle/cup	
Drinking from a sip cup		Self-feeding	

Breast Feeding: _____ Currently _____ Weaned _____ Never

Number of times currently breast fed per day _____ Weaned from breast feeding at age: _____

FEEDING CONCERNS

Describe any current feeding problems: _____

Food likes: _____

Food Dislikes: _____

Areas of difficulty:

_____ Chewing _____ Drooling _____ Communicating Needs _____ Swallowing

_____ Transitioning between foods _____ Understanding Words _____ Jaw Shifts/Slides/Juts

Current Feeding Adaptations

Please select the feeding adaptations currently being used and provide any additional details below:

_____ Thickened liquids Consistency: _____

_____ Spoon/Pudding Consistency

_____ Adapted Utensils

Details: _____

_____ Adapted Seating

Details: _____

_____ Calorie Supplements

Details: _____

_____ Tube Feeding

Amount: _____ Times per day _____ By Bolus/Continuous

SPEECH, LANGUAGE, & COMMUNICATION

Do you have concerns regarding the child's speech, language, and communication skills? _____ Yes _____ No

Speech Development

When did the child approximately began to do following activities:

When did child begin?	Age (in months)	Milestone:	Age (in months)
Babbling		Putting 2 words together	
Saying first words		Using short sentences	
Naming familiar objects			

What were the child's first words: _____

Communication

Does the child:	Yes	No
Have speech that is understood by most people?		
Respond correctly to yes/no questions?		
Follow simple instructions?		
Respond when name is called?		
Stutter?		
Recognize objects, people, and places?		

Please describe current speech concerns: _____

Communication Types

The child's primary method of communication is: _____ Verbal _____ Non-Verbal

Is an augmentative communication device used: _____ Yes _____ No

Details: _____

Select the primary methods of verbal communication used:

_____ None _____ 2 Word phrases _____ Vocalizations

_____ Complete Sentences _____ Single word phrases

Select the primary methods of non-verbal communication used:

_____ Facial Expressions _____ Gestures _____ Body Language

_____ Pointing _____ Manual Sign Language _____ Eye Gaze

HOME ENVIRONMENT

Who Lives in The Home

Select all that apply:

_____ Birth Mother _____ Birth Father _____ Step-mother _____ Step-father _____ Adoptive Mother

_____ Adoptive Father _____ Grandmother _____ Grandfather _____ Sibling(s) Ages: _____

_____ Other relative _____ Legal Guardian Comments/Other details: _____

Adoption

Was the child adopted? _____ Yes _____ No Age of child at adoption: _____

Please provide additional details of adoption (e.g. country, child's prior living situation, etc.) _____

Type of Home

☐ Single Level Home ☐ Ground Floor Apartment ☐ Assisted Living Facility ☐ Group Home
☐ 2 Level Home ☐ Upper Level Apartment ☐ Skilled Nursing Facility
☐ Other: _____

Stairs

Are there stairs to get into the home? ☐ Yes ☐ No How many? _____

Handrail? ☐ Right side ☐ Left side ☐ None

Are there stairs inside the home? ☐ Yes ☐ No How many? _____

Handrail? ☐ Right side ☐ Left side ☐ None

Is there a ramp to get into the home? ☐ Yes ☐ No

Where is the bathroom located? ☐ Main Level ☐ Upper Level ☐ Both Levels

Where is the bedroom located? ☐ Main Level ☐ Upper Level ☐ Both Levels

EQUIPMENT

Does the child use any equipment to assist with activities, mobility, or positioning? ☐ Yes ☐ No

Equipment presently used (Please select all that apply):

Equipment:	Approximate Age	Details	Uses at Home	Uses at school/day care
Braces				
Walker				
Stander				
Manual Wheelchair				
Power Wheelchair				
Hoyer Lift				
Weighted Vest				
Hand Splints				
Track System				
Other:				
Other:				
Other:				

Details/Comments: _____

OTHER SERVICES

Does the child currently receive any services? ☐ Yes ☐ No

Therapy Service	Type (Individual, Group, Or Both)	Status (Ongoing, Discontinued, Not Started)	How Often?	Where?
Assistive Technology				
Audiology				
Behavior Therapy				
Developmental Therapy				
ECI Services				
Intensive Suit Therapy				
Vision Therapy				
Nutrition				
Occupational Therapy				
Physical Therapy				
Social Work				
Speech/Language Therapy				
Developmental Follow-Up Clinic				
Other				

SCHOOL

Does your child have an IFSP? ____ Yes ____ No

Does your child have an IEP from school? ____ Yes ____ No

Grade in school: _____ Where: _____

Has your child had a psychological or neuropsychological evaluation completed? ____ Yes ____ No

Comments: _____

Community Activities

Is the child involved in any community groups or sports activities? ____ Yes ____ No

If yes, please provide more details:

Home Program

Do you currently perform a home program with the child? (e.g. stretching, strengthening activities, brushing, etc.)

____ Yes ____ No If yes, please explain: _____
