DIXIE REGIONAL PEDIATRIC REHABILITATION

Today's Date_____

Patient's Name_____ Date of Birth _____/_____/_____
Parent/Guardian _____ Phone: Home _____Cell: _____
Primary Care Physician _____ Referred by_____
With whom does the child live? (Include siblings) _____
School/Preschool _____Grade: _____
Please describe your primary concerns and the reason for your visit today _____
_____

*When was the problem first noticed/diagnosed? *Required Information* **Month** _____**Day** _____**Year** _____

INTERVENTION HISTORY (Please list the name and location of the provider your child has seen. For example, PT, OT, Speech, Early Intervention, Behavior Specialist, Psychologist, etc.)

_____
_____

Medical History – Be as specific as possible, if more space is needed attach additional pages

Pregnancy/Delivery (☐ Unknown, child was adopted)
Y ☐ N ☐ Problems with mother or baby during pregnancy?
Describe: _____
Y ☐ N ☐ Premature? If yes, gestational Age_____ Birth Weight_____
Y ☐ N ☐ Problems with delivery: ☐ Normal ☐ Caesarian ☐ Breech ☐ Multiple Babies ☐ other: _____
Y ☐ N ☐ Prescription/Over the counter or herbal remedies taken during pregnancy? _____
Y ☐ N ☐ Alcohol/Drugs taken during pregnancy?
_____
Y ☐ N ☐ At birth, did your child have problems with?
☐ Infection ☐ Blueness ☐ Starting to breathe ☐ Jaundice
☐ Other, specify: _____

General Health
Please list all medical diagnoses given by a doctor regarding your child: ☐ NONE ☐ _____
_____
Please list all prescribed/over-the-counter medication/herbal remedies your child currently takes: ☐ NONE ☐ _____
_____
Please list all Allergies/Adverse Drug Reactions: ☐ NONE _____
_____
Please list all hospitalizations/operations/invasive procedures your child has had: ☐ NONE ☐ _____
_____
Y ☐ N ☐ Current infection or colonization with an antibiotic-resistant germ (MRSA, VRE); Name of treating doctor: _____
Y ☐ N ☐ Nutritional/feeding concerns? _____
Y ☐ N ☐ History of reflux? _____
Y ☐ N ☐ Is your child experiencing any pain? If so, describe type and frequency of the pain._____
Y ☐ N ☐ Does your child have sleep difficulties? _____

Eyes and Vision
Y ☐ N ☐ Formal vision test? When? _____Where? _____
Describe vision test results: _____
Y ☐ N ☐ Does your child currently wear glasses?
Y ☐ N ☐ Is there vision loss in the family/extended family? Who?
_____

Ears and Hearing
Y ☐ N ☐ Current/past ear infections/ pain/ fluid/ drainage in ear? What age did ear infections begin? _____ How often did they occur? _____
Last ear infection? _____ How was it treated? _____
Was treatment successful? Y N
Y ☐ N ☐ Ear surgery or tubes? _____
Y ☐ N ☐ Hearing problems? _____
Y ☐ N ☐ Newborn Hearing Screening? Name of birth hospital/Results_____
Y ☐ N ☐ Has hearing been tested? When? _____ Where? _____
Describe test results_____
Y ☐ N ☐ Has child ever worn hearing aid? _____
Y ☐ N ☐ Is there hearing loss in the family/extended family? Who?
_____

Speech and Language
Y ☐ N ☐ Has speech/language been tested?
When? _____ Where? _____
Describe test results _____
Has your child had problems with?
Y ☐ N ☐ Fluency or stuttering? _____
Y ☐ N ☐ Using eye contact when talking with others? _____
Y ☐ N ☐ Is there speech or language difficulties in the family/extended family? Who? _____

Temperament
Has your child ever displayed any of the following that are concerning to you or not related to their age?
Y ☐ N ☐ Short attention span? _____
Y ☐ N ☐ Frequent frustration or temper outbursts? _____
Y ☐ N ☐ Difficulty in social situations or interacting with peers?
Explain: _____
Y ☐ N ☐ Difficulty transitioning from one activity/place to another?
Explain: _____

Your Learning Needs (Parent)
Do you have needs with?
Y ☐ N ☐ Language? Language Preference_____
Y ☐ N ☐ Loss of Vision?
Y ☐ N ☐ Hearing Loss?
Preferred learning method? ☐ Demonstration ☐ Explanation
☐ Printed materials ☐ Class

Place patient sticker here

Parent or Guardian_____
Signature Date

Patient will see: (circle one or more) Physical therapy Occupational Therapy Speech Therapy Social Work