PHYSICAL THERAPY AT St Luke's Pediatric Therapy

PATIENT MEDICAL & CASE HISTORY

Patient Name:_____ Today's Date:_____

Person completing this form:_____

Date of Birth:_____ Soc. Security #:_____ Circle: Male Female

Home Address: _____

Primary Phone #: _____

Mother's Name:_____ DOB:_____

Mother's Address if different from patient:_____

Mother's Primary Phone #:_____ Other Phone #:_____

Mother's Employer:_____ Occupation:_____

Father's Name: _____ DOB:_____

Father's Address if different from patient:_____

Father's Primary Phone #: _____ Other Phone #:_____

Father's Employer:_____ Occupation:_____

Siblings Names & Ages:_____

_____

Primary Care Physician (PCP):_____ PCP Phone:_____

Referring Physician:_____ Ref. Physician Phone:_____

Specialist Physician: _____ Spec. Physician Phone:_____

Medical History: Please list current medical diagnoses and date of diagnosis: _____

_____

_____

Surgical/Hospitalizations History:_____

_____

_____

What are your primary concerns?_____

_____

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Patient's current weight:_____ Current Length:_____ Height/Weight Percentile:_____

Ethnicity:_____ Religion: _____ Primary language:_____

Has your child had any of the following this year? (Check all that apply)

Physical therapy_____ Occupational therapy_____ Speech therapy_____ Feeding Therapy_____
Early Intervention_____ Home Care____

Are you transferring from another Facility? Yes / No_ If yes/please list: _____

Medication List

Start Date	Drug	Dose	Frequency/Route	Stop Date

Allergies: Please list all:_____

Birth History:

Gestational Age: _____ Duration of Labor:_____ How long did you push?_____

Born Prematurely: Yes / No If yes: Chronological Age:_____

Mother's age at time of birth:_____Delivery: Vaginal / C-Section / Vacuum / Nuchal Cord / other_____

Utero Position:_____ Infant Position at Birth: Vertex / Breech / Transverse / other_____

Known Uterine Abnormalities for mother? Yes / No If yes, describe:_____

Fertility Treatments Yes / No If yes, list fertility medications:_____

Child's Weight at Birth:_____ Length at Birth:_____ Head Circumference:_____

Apgar Scores: _____ Birth order:_____ OB/Gyn and/or Mid-Wife:_____

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Name of Hospital/Birth Center Child was born:_____

Was child breast fed Yes / No Length of time child breastfed?_____

When did child start using a bottle_____

When did child start using formula_____ Type of formula_____

Did your child have trouble feeding Yes / No (breast: left /right; bottle feeding)

Did the child require any of the following: **NICU**: Yes / No **Special Care Nursery**: Yes / No **Oxygen:** Yes / No

Incubator: Yes / No **Other:**_____

Did the child receive therapy services prior to returning home (in NICU, PICU, or nursery)? Yes / No

If yes, please list:_____

First Child Yes / No **Single Birth** or **Multiple Birth** if multiple birth: **Twin A / Twin B**

List any complications during pregnancy (bed rest/ low back pain/ leg pain):_____

_____

List any complications during Delivery:_____

List any medications taken by mother during pregnancy & Delivery:_____

Did child seem stuck in one position for the last part of pregnancy Yes / No If yes, describe:_____

How many weeks was the child stuck _____weeks

Dose the infant have a head tilt preference: Left / Right Rotation Preference: Left / Right

Any other children with tight neck muscles and or misshapen head Yes / No

Has child ever been treated for Torticollis Yes / No Jaundice Yes / No

Did child have a normal head shape at birth? Yes / No If No, describe:_____

Who noticed misshapen head_____ What age? _____

Does the child have any facial asymmetry? Yes / No If Yes, describe:_____

Time child spends in car seat per day _____ Type of car seat_____

Time child spends in swing per day_____

Other infant sitting devices used and time spent per day _____

How often is baby held?_____ What position?_____

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Time child spends on back daily:_____ Time child spends on belly daily:_____

Belly increments per day?_____ Age Initiated Belly Time?_____

Child's sleep position (birth – 1 year) **Supine** (on back) / **Side** / **Prone** (on tummy) / Other: _____

Do you have any concerns with your child's sleeping pattern?_____

Any congenital anomalies (circle any that apply)

Hip dysplasia: Left / Right **Hip subluxation**: Left / Right **Fractured clavicle**: Left / Right

Forceps abrasion: Left / Right **Brachial Plexus injury**: Left / Right

Cephalohematoma: Parietal - Left / Right, small / medium / large
Occipital – Left / Right, small / medium / large

Diagnostic Tests (circle any that apply)

X-Ray **MRI** **CT Scan** **Ultra Sound** **Swallowing Study** **Vision Exam**

Please list the age of child at the following milestones (in months):

Mouthing of toys/hands: _____ Reached for Toys:_____Started babbling:_____Held Head up:_____ Rolled over: _____

Sat without support: _____Started crawling: _____Walked independently: _____ Toilet Trained:_____

Physical Therapy specific questions:

Has or does the child use braces or orthotics? _____

Has or does the child use any assistance devices:_____

Has the child seen an orthopedic doctor? (Who?, When?, Why?)_____

_____

Occupational Therapy specific questions:

Play Skills:

What does your child like to play with?_____

Describe your child's attention to structure and unstructured play:_____

_____

How does your child spend unstructured time?_____

Describe the child's social behavior with others: _____

Self Help:

How much assistance is needed with self –dressing?_____

Can the child complete buttons, zipper, snaps? Yes / No

Does your child react negatively to noise, textures, or movement?_____

How does your child handle changes in routine?_____

_____

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Speech/Feeding Therapy specific questions:

New Born Hearing Screening Results:_____

Has your child had a hearing screening? Yes / No If yes, what were the results?_____

Does child respond to **Soft** or **Moderate** sounds? Yes / No Does child seem to listen to people's voices? Yes / No

Does your child snore? Yes / No Dose your child have frequent ear infections? Yes / No

Can child follow instructions which are expected for his/her age? Yes / No

Has the speech progress ever been interrupted or reversed? Yes / No If yes, please describe:_____

_____

When was the problem with speech/language first noticed?_____

Did the speech problem follow an illness, accident, or unusual occurrence?_____

Please list the age of child at the following milestones (in months):

Started Eating Table Food:_____ Cereal introduced:_____ Pacifier use:___ First words:_____

Put 2 words together:_____ Put 3-4 words together:_____ Sentences:_____

Does the child like to listen to children's stories? Yes / No

Can the child independently drink from a cup? Yes / No

Child's Meal time Position? Highchair_____ Booster Seat_____ Bumbo_____ Car Seat_____ Other_____

Reflux ? Yes / No If so Reflux Medication:_____

Has your child ever used feeding utensils? Yes / No If yes, is assistance needed for success? Please describe:_____

_____

Does the child have food sensitivities? Yes / No If yes, explain: (sounds, textures, smells, etc.)_____

_____

How does your child typically communicate? (circle one)

Gestures / single words / short phrases / sentences

Is your child understood by others or just family members?_____

Patient's Signature:_____ Date:_____

Legal Guardian Signature: _____ Print Guardian's Name:_____

Therapist's Signature/Date:_____