ProActive PEDIATRIC THERAPY

Medical History Questionnaire

DATE_____FORM COMPLETED BY_____ RELATION TO CHILD_____

PATIENT INFORMATION

CHILD'S NAME_____
(First) (Middle) (Last)

DATE OF BIRTH_____ AGE_____ SEX M / F

PRIMARY CARE PROVIDER_____

CURRENT MEDICATIONS_____

ALLERGIES_____

CONCERNS AND GOALS

WHAT ARE YOUR MAIN CONCERNS FOR YOUR CHILD?_____

_____

_____

WHAT WOULD YOU LIKE TO SEE YOUR CHILD ACHIEVE?_____

_____

WHAT ARE YOUR GOALS_____

_____

SOCIAL HISTORY

GUARDIAN 1_____ GUARDIAN 2_____

PARENTS ARE CURRENTLY (circle one): Married / Separated / Divorced / _____

CHILD LIVES WITH_____

OTHER CHILDREN OR FAMILY MEMBERS IN THE HOME? Y / N IF YES, PLEASE LIST NAMES/AGES_____

_____

IS CHILD ADOPTED? Y / N IF YES, WHEN? _____ IN FOSTER CARE? Y / N IF YES, HOW LONG? _____

PARENTS WORK OUTSIDE OF HOME? GUARDIAN 1_____ GUARDIAN 2_____

CHILD IS: AT HOME WITH CARE PROVIDER: _____ AT DAYCARE:_____
(where, hours/days)

AT SCHOOL _____
(where) (grade) (teacher name)

ProActive PEDIATRIC THERAPY MEDICAL HISTORY

FORMAL DIAGNOSIS? _____

WHEN WAS YOUR CHILD DIAGNOSED AND BY WHOM?

_____

WHO IS YOUR CHILD'S PRIMARY CARE PROVIDER?_____

DOES YOUR CHILD RECEIVE MEDICAL CARE FROM OTHER SPECIALITY PROVIDERS? Y / N

PLEASE LIST:_____

ANY OTHER AGENCIES FOR THERAPY SERVICES? Y / N IF YES, _____
(please list where and with whom)

MOTHER'S PREGNANCY:

INFECTIONS/ILLNESS/INJURIES? Y / N Please explain_____

MEDICATIONS DURING PREGNANCY? Y / N Please explain_____

DRUG/ALCOHOL/TOBACCO USE? Y / N Please explain_____

UNUSUAL STRESS? Y / N Please explain_____

LABOR AND DELIVERY:

NATURAL ONSET OF LABOR OR INDUCED? (circle one)

CHILD'S BIRTH HISTORY:

BIRTH WEIGHT:_____

BORN PREMATURE? Y / N IF SO, HOW MANY WEEKS?

_____

ADMITTED TO NICU? Y / N IF SO, WHY AND OR HOW LONG? _____

AT BIRTH OR AS A NEWBORN, DID YOUR CHILD HAVE:

BREATHING PROBLEMS OR NEED BREATHING SUPPORT? Y / N IF SO, PLEASE EXPLAIN: _____

_____

HEART PROBLEMS? Y / N IF SO, PLEASE EXPLAIN: _____

BIRTH INJURIES OR ABNORMALITIES? Y / N IF SO, PLEASE EXPLAIN:

_____

SEIZURES? Y / N_____

INFECTIONS? Y / N_____

ProActive
PEDIATRIC THERAPY

CHILD'S MEDICAL HISTORY:

HOSPITALIZATIONS? Y / N IF SO, PLEASE EXPLAIN:_____

SURGERIES? Y / N IF SO, PLEASE EXPLAIN:_____

SHUNT? Y / N PLEASE DESCRIBE_____

ISSUES WITH THE FOLLOWING?

VISION EXAM? Y / N IF YES, BY WHOM?_____ WHEN?_____

HEARING EXAM? Y / N IF YES, ANY CONCERNS?_____

Has your child had an ear infection in the past or currently have ear infections? Y/N. Please explain: _____

If so, how many ear infections has your child had? _____

Did your child have ear tubes or currently have ear tubes? Y/N. Please explain: _____

SLEEP:

Is your child able to fall asleep on their own? Y/N Please explain: _____

Does your child achieve deep sleep or is it restless sleep? Please explain: _____

Does your child wake frequently at night? Y/N Please explain: _____

FEEDING HISTORY

BREAST FED? Y / N IF YES, HOW LONG?_____

BOTTLE FED? Y / N IF YES, HOW LONG?_____

SWITCH FORMULAS? Y / N PLEASE EXPLAIN_____

FREQUENT SPIT UPS OR VOMITTING? Y / N PLEASE EXPLAIN: _____

REFLUX? Y / N IF YES, DID IT REQUIRE TREATMENT? Y / N _____

PROBLEMS GAINING WEIGHT? Y / N _____

DIFFICULTIES TRANSITIONING OFF BOTTLE OR TO FOOD? Y / N_____

HISTORY OF FEEDING DIFFICULTIES? Y / N PLEASE EXPLAIN:

_____

ProActive
PEDIATRIC THERAPY

DEVELOPMENTAL HISTORY

PLEASE PROVIDE INFORMATION ON WHEN YOUR CHILD:

ROLLED OVER_____ SAT INDEPENDENTLY_____

CRAWLED_____ WALKED_____

SPOKE FIRST WORD_____ SPOKE FIRST SENTENCE_____

TOILET TRAINED (DAY)_____ (NIGHT)_____

Personal

Current Height_____ Current Weight _____