PEDIATRIC PATIENT HISTORY

PHYSICAL THERAPY CARE & AQUATIC REHAB OF FORT BEND

CHILD'S INFORMATION

LAST NAME	MI	FIRST NAME	DATE OF BIRTH

PARENT/GUARDIAN INFORMATION

NAME	CELL	WORK	HOME	RELATIONSHIP

WHO IS AUTHORIZED/ALLOWED TO:

SHARE MEDICAL INFORMATION	PICK UP YOUR CHILD

PRIMARY LANGUAGE(S) SPOKEN AT HOME?

PLEASE LIST YOUR CHILD'S ALLERGIES

Medication:

Food:

Skin:

Does your child need an Epi Pen for their allergies? 0 Yes 0 No Will your child have it with them at therapy? 0 Yes 0 No

NAME	CELL	WORK	HOME	RELATIONSHIP

Primary Care Doctor:	Phone:
Referring Doctor:	Phone:

MEDICAL HISTORY

Was your child delivered at Full Term? 0 Yes 0 No Weeks of gestation:

What is the medical diagnosis?

Describe your child's birth:

INDICATE THE AGE IN MONTHS THAT YOUR CHILD FIRST:

Rolled over	Sat alone	Got on hands and knees	Crawled	Pulled up standing	Walked alone

Current Weight:	Current Height:	Immunizations current?	0 YES 0 NO

List your child's medications:

What concerns do you have for your child?

How does your child communicate his/her wants & needs?

What would you like your child to accomplish in physical therapy?

What equipment do you have for your child? (braces, wheelchair, etc)

Do you have equipment needs? 0 Yes 0 No

Does your child complain of any pain? 0 Yes 0 No

Does your child have any problems with vision, hearing or speech? 0 Yes 0 No

Is your child in school? 0 Yes 0 No **SCHOOL:** **GRADE:**