HIGH DESERT PHYSICAL REHAB GROUP

PEDIATRIC HISTORY and PHYSICAL

Name _____ **DOB** _____ **Age** _____ **Sex** _____

Parent/Guardian Name _____

What problems bring you to therapy? _____

_____

_____

Have you had therapy before? _____ **If so, when and where?** _____

_____

_____

May we request records from your previous provider? _____

Medications: _____

_____

_____

Allergies, including food: _____

_____

Has your child been seen by a Medical Specialist? _____

_____

_____

Has your child ever been Hospitalized? _____

Important Medical History: _____

_____

_____

Important Surgical History: _____

_____

Was your child born Premature? ____ **If yes, in what week gestation?** _____

Does your child have Seizures? ____ **If yes, please describe the type, frequency and duration.** _____

_____

Diabetes _____ **Cancer** _____
Heart Problems _____ **Pacemaker** _____
Breathing Disorder _____ **Pneumonia** _____
Vision Problems ____ **Wear Glasses** _____
Hearing Problems____ **Wear Hearing Aides** _____
Frequent Ear Infections____
Genetic Disorder____ **Please specify** ____
Orthopedic Problems _____ **Fractures** _____
Cleft Lip or Palate _____
Feeding Disorders _____
Speech Problems _____
Attention Deficit ____ **Hyperactivity** _____
Psychiatric Problems _____
Autism ____ **Pervasive Spectrum Disorder** _____
Developmental Delay _____
Coordination Deficits _____
Handwriting Problems _____
Cognitive/Perceptual Deficits _____
Other _____

Please provide any details to your above answers _____
_____
_____
_____

What should we do in the event of a seizure? _____
_____

Do we have permission to take your child to the bathroom? _____

In the event of an emergency, do we have your permission to call an Ambulance? _____

Please list any other Special Instructions _____
_____
_____

_____ _____
Parent/Guardian **Date**