First Choice Physical Therapy, Inc.

PEDIATRIC MEDICAL HISTORY and DEVELOPMENT

Patient Name:_____

Patient Date of Birth: _____

Today's Date: _____

Thank you for taking the time to complete this form on your child. The information you provide is valuable in assessing your child's developmental skills.

Mother's Name: _____ Father's Name: _____

Diagnosis/Chief Complaint/Reason for this visit: _____

_____

Referring Physician: _____

Has your child previously received Physical, Occupational, or Speech therapy? YES NO
If yes, when and where? _____

List any previous medical conditions: _____
_____

List any previous surgeries: _____
_____

List any current medications:_____
_____

Allergies (Medications, Latex, Environmental)? _____
_____

BIRTH INFORMATION:

Birth weight: _____ Gestational Age _____ Apgars _____

Vaginal Delivery? YES / NO C-section? YES / NO Emergency? YES / NO

Complications/Health Problems (baby or mom): Check all that apply

____Diabetes ____Measles ____Strep B ____Toxemia ____Respiratory
____Premature labor ____Pre-eclampsia ____Forceps ____Vacuum
____NICU ____Ventilator ____Jaundice ____Heart Problems
____Poor suck Other_____

DAYCARE OR SCHOOL INFORMATION:

What daycare/school does your child attend? _____Grade: ____
How often does he/she attend? _____days per week _____hours per day
Are there any areas of daycare/school that your child has difficulty with? _____
_____

_____

CHILD'S DEVELOPMENTAL HISTORY:

Is your child having difficulty rolling, sitting, or walking? YES / NO

Does your child have problems with balance or coordination? YES / NO

Does your child play with appropriate toys for his/her age? YES / NO

Do you have concerns with your child's:
Eating skills? YES / NO Eye-hand coordination? YES / NO Dressing skills? YES / NO

Grooming/hygiene? YES / NO Handwriting? YES / NO

Hand preference? Left / Right

Does your child have any bowel/bladder difficulties? YES / NO
If yes, please describe _____

MILESTONES - Please list approximate age the child accomplished the following:

Lift head while on tummy _____
Sat without support_____
Stood alone _____
Dress/Undress self _____
Started solid food _____
Used fork _____
Drank from open cup _____
Dry during the night _____
Said first words _____
Rolled over _____
Crawled _____
Walked alone _____
Button/Zip clothes _____
Held cup _____
Drank from sippy cup _____
Dry during the day _____
Babble (dada,baba, etc.) _____
Said combined words _____

SPEECH/HEARING/VISION:

Does your child respond when his/her name is called? YES / NO
Does your child follow simple directions? YES / NO
Approximately how many words does your child have? _____

Has your child ever had a hearing test? YES / NO
If yes, did they pass or fail? _____
Does your child wear a hearing aid? YES / NO

Has your child ever had a vision test? YES / NO
If yes, what were results? _____
Does your child wear glasses? YES / NO

FEEDING:

Does your child have difficulty with any of the following:

Poor suck? YES / NO
Chewing? YES / NO
Finger feeding? YES / NO
Reflux/Vomiting? YES / NO
Food textures? YES / NO
Swallowing? YES / NO
Gag/Choke often? YES / NO
Spoon use? YES / NO
Picky eater? YES / NO
Requires feeding tube? YES / NO

CHILD'S DEVELOPMENTAL HISTORY (continued):

SENSORY:

Do your child's hands, feet, or tummy seem overly sensitive to touch? YES / NO

Does your child:

Seem distractible or overactive? YES / NO Which? _____

Tolerate tooth brushing? YES / NO

Hesitate on uneven surfaces? YES / NO

Have difficulty positioning in a chair? YES / NO

Push/bump into other children? YES / NO

Seem generally weak? YES / NO

Have difficulty judging the height/depth of stairs? YES / NO

Walk or go down stairs heavily (stomping feet)? YES / NO

Have difficulty participating in sports with other children? YES / NO

Have a fear of using playground equipment (see-saw, swing, etc.)? YES / NO

Have difficulty catching him/herself when falling? YES / NO

Not hear certain sounds? YES / NO

Respond negatively to certain sounds (running away, crying)? YES / NO

Seem to always seek activities with pushing, pulling, and jumping? YES / NO

Demand to only wear certain clothes all the time? YES / NO

Avoid getting hands messy? YES / NO

Get bothered by face washing or hair brushing? YES / NO

Spin, rock, or hit self with distressed? YES / NO

Have difficulty keeping eyes on task/activity? YES / NO

Close one eye or tip head back when looking at something? YES / NO

Anything else not mentioned above that you would like your therapist to know about your child? _____

_____

_____

_____