Northeast Hospitals
The Center for Rehabilitation and Sports Medicine

Caregivers' name(s)/ Relationship(s): _____
Persons authorized to transport child from therapy other than above_____
_____

Siblings and their ages:_____

Medical History
Age_____ Current height _____ Current weight_____
Other Medical Professionals involved in your child's care (specialist, orthotist, etc)
_____

Please describe your main concern regarding your child:
_____
_____

What are the goals you wish to attain through therapy for your child:
_____
_____

Does the child have a medical diagnosis? ☐ Yes ☐ no, If yes what is it? _____
Is your child up to date on his/her immunizations? ☐ Yes ☐ no

Medications – Please list prescriptions and over the counter medications

Medication	Dosage	Purpose

Please list any Food/Drug or other allergies:
_____

Surgery History/Hospitalization – Please list

	Date

Has your child had any other therapy services? ☐ Yes ☐ no If yes, please describe:
_____

Pregnancy/Birth History:
Was your child born full term? ☐ Yes ☐ no If no, how many weeks? _____
Was your child a multiple birth? ☐ Yes ☐ no Weight at birth: _____
How was your child delivered? ☐ Vaginal birth ☐ Cesarean section birth
Were there any complications during pregnancy? ☐ Yes ☐ no If yes, please describe _____

Medical History Has your child had any of the following conditions? (Check all that apply)

Condition	Yes	No	Comments
Allergies			
ADD/ADHD			
Arthritis (JRA, OA, etc)			
Autism/PDD			
Chronic ear infections			
Diabetes			
Nerve injury			
High fevers			
Speech/language delay			
Hearing problems			
Vision difficulties			
Congenital disorder			
Meningitis			
Heart disease			
Developmental delay			
Orthopedic injuries			
Brain injury			
Spinal cord injury			
Cerebral palsy			
Sensory processing disorder			
Respiratory issues			
Gastrointestinal disorder			
Seizures			
Psychological issues/behavioral issues			
Learning disability			
Other_____			

Developmental History: At what age did your child…?

	Age		Age
Lift head while on his/her stomach		Creep on hands and knees	
Roll over back to stomach		Pull to stand	
Roll over stomach to back		Sit up independently	
Sit up when placed		Crawl on belly	
Pull to stand		Walk	

Education and Activity:

Does you child attend school? ☐ Yes ☐ no If yes what school/grade _____

Has your child had Early Intervention? ☐ Yes ☐ no Is there an IEP or 504? ☐ Yes ☐ no

Is your child involved in any sports activities? ☐ Yes ☐ no

If yes, what activities? _____How many times per week_____

Person completing form _____ relationship to child_____

Signature _____Date_____

Therapist Signature_____Date_____