



PEDIATRIC MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____

How did you find out about Kinetic Edge?

- Printed Ad Online Social Media Email Blast Physician Returning Client Mailing Radio
- From friend/family member: _____ Other: _____

What are your primary concerns:

Pregnancy / Delivery

- Pregnancy Proceeded: Without Complications
- With Complications
- Eclampsia
 - Gestational Diabetes
 - Multiple Births
 - Polyhydramnios
 - Positive for Cytomegalovirus 'CMV'
 - Positive for Herpes
 - Positive for HIV
 - Positive for Strep B
 - Pre-eclampsia
 - Premature Labor
 - Substance Exposure
 - Toxemia
 - Other _____

Length of Pregnancy (in weeks): _____ Prenatal care was: Received Not Received

- Delivery Proceeded: Without Complications
- With Complications
- Abruptio Placenta
 - Breech Presentation
 - Low Birth Weight
 - Negative Vacuum
 - Non-progressive/unproductive Labor
 - Occiput Posterior Position (Face Up)
 - Placenta Previa
 - Premature Rupture of Membranes
 - Transverse Presentation
 - Prolapsed Cord
 - Use of Forceps
 - Uterine Rupture
 - Umbilical Cord Wrapped Around Neck
 - Other _____

Delivery was: Vaginal C-section Emergency C-section Length of child's hospital stay: _____

Needed to be transferred to another hospital? Yes No Transfer Hospital: _____

Birth Weight: _____ Birth Height: _____

Multiple child pregnancies: # of live births _____ # of still births: _____

Comments: _____

Following Birth

- Complications Following Birth
- | | |
|---|--|
| <input type="checkbox"/> Anemia of Prematurity | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Bronchopulmonary Dysplasia 'BPD' | <input type="checkbox"/> Meconium Aspiration |
| <input type="checkbox"/> Cleft Lip | <input type="checkbox"/> Necrotizing Enterocolitis 'NEC' |
| <input type="checkbox"/> Cleft Palate | <input type="checkbox"/> Neonatal hypoxia |
| <input type="checkbox"/> Club Foot | <input type="checkbox"/> Oxygen dependency |
| <input type="checkbox"/> Cytomegalovirus | <input type="checkbox"/> PDA |
| <input type="checkbox"/> ECMO | <input type="checkbox"/> Positive dependency |
| <input type="checkbox"/> Failure to Thrive | <input type="checkbox"/> Respiratory Distress Syndrome |
| <input type="checkbox"/> Hyperbilirubinemia | <input type="checkbox"/> Respiratory Syncytial Virus 'RSV' |
| <input type="checkbox"/> Intrauterine Growth Retardation 'IUGR' | <input type="checkbox"/> Retinopathy of Prematurity 'ROP' |
| <input type="checkbox"/> IVH Bleed Grade: _____ | <input type="checkbox"/> Thrombocytopenia (Low platelet count) |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Ventilator Dependency |
| | <input type="checkbox"/> VP Shunt |

Diagnosed or Suspected Syndromes

Current Medications:

Current Vitamins, Herbs, Minerals, Homeopathics

Hearing Test

- Never Tested, No Concerns
- Never Tested, Have Concerns
- Normal Test Results
- Abnormal Test Results

Last Test Date: _____

Vision Test

- Never Tested, No Concerns
- Never Tested, Have Concerns
- Normal Test Results
- Abnormal Test Results

Last Test Date: _____

Current Physicians:

Current Physicians:		
Name:	Specialty:	Reason:

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Does the child have:

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergies
<input type="checkbox"/> Arteriovenous malformation (AVM)
<input type="checkbox"/> Anoxic brain injury
<input type="checkbox"/> Asthma/respiratory breathing problems
<input type="checkbox"/> Autism
<input type="checkbox"/> Baclofen Pump
<input type="checkbox"/> Cerebral Palsy (CP)
<input type="checkbox"/> Cerebral Vascular Accident (CVA)
<input type="checkbox"/> Chronic Ear Infections | <input type="checkbox"/> Colic
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Down Syndrome
<input type="checkbox"/> Hip subluxation
<input type="checkbox"/> Hydrocele
<input type="checkbox"/> Laryngomalacia
<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Periventricular Leukomalacia
<input type="checkbox"/> Reflux | <input type="checkbox"/> Scoliosis Degrees? _____
<input type="checkbox"/> Seizure Condition
<input type="checkbox"/> Sleep disorder
<input type="checkbox"/> Sleep problems
<input type="checkbox"/> Shunts
<input type="checkbox"/> Torticollis
<input type="checkbox"/> Traumatic brain injury (TBI)
<input type="checkbox"/> Tube Feeding
<input type="checkbox"/> Tubes in ears
<input type="checkbox"/> Vagal Nerve Stimulator
<input type="checkbox"/> None |
|--|---|--|

Other Medical Conditions: _____

Orthopedic Conditions: _____

Comments: _____

Developmental History

Is the child able to:	Child can accomplish (Yes/No)
Bring both hands to mouth	
Buttoning pants/shirt	
Come to sitting from lying position	
Creeping or crawling alone	Age in months:
Fully toilet-trained	
Grabbing a toy	
Holding head up alone	
Pulling self to standing position	
Rolling over	Age in months:
Self-Bathing	
Self-Dressing	
Sitting alone without support	Age in months:
Standing unsupported	Age in months:
Tying shoes	
Walking independently	Age in months:

Zippering/unzipping jacket

Is your child: Right Handed Left Handed Neither
Concerns about handwriting? Yes No Describe: _____

How does your child get around the house? _____

Favorite Toys / Activities: _____

Description of Child:

- Active Cautious Distractible Insecure Playful
- Affectionate Curious Fearful Motivated Shy
- Aggressive Demanding Fearless Passive Stubborn
- Calm Difficult to Comfort Fussy Persistent Withdrawn
- Other: _____

Social / Emotional Skills:

- Is easily distracted Prone to emotional outbursts Only plays with adults
- Calms self easily Doesn't allow other to join in play Prefers to play alone
- Gets angry/frustrated easily Has difficulty making friends Has difficulty with separation
- Is aggressive towards others Plays with peers Has poor eye contact

Feeding

Describe any feeding problems: _____

Food Likes: _____ Food Dislikes: _____

Areas of Difficulty:

- Chewing Drooling Transitioning Between Foods Jaw shifts/slides/juts
- Communication Needs Swallowing Understanding Words

First Words: _____

Primary Communication: Verbal Non-Verbal None

Methods of Communication Used:

- Vocalizations 2 word phrases Facial expressions Manual Sign Language Pointing
- Single words Complete sentences Body Language Gestures Eye Gaze

Describe Current Speech Concerns: _____

Home Environment:

Child lives with: (Please select all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Birth mother _____ | <input type="checkbox"/> Step-mother _____ |
| <input type="checkbox"/> Birth father _____ | <input type="checkbox"/> Step-father _____ |
| <input type="checkbox"/> Adoptive mother _____ | <input type="checkbox"/> Grandmother _____ |
| <input type="checkbox"/> Adoptive father _____ | <input type="checkbox"/> Grandfather _____ |
| <input type="checkbox"/> Legal guardian _____ | <input type="checkbox"/> Other relative _____ |
| <input type="checkbox"/> Foster mother _____ | <input type="checkbox"/> Foster father _____ |

Siblings; Please list names and ages: _____

Additional Comments: _____

Foster Care:

If child is in foster care, please list case manager and contact info: _____

If child is in foster care, has child's parent(s) authorized treatment? Yes _____ No _____

If child is in foster care, additional information that we should know included but not limited to parental rights, visitation arrangements, will parents be attending therapy appointments, etc? _____

Adoption:

Age at Adoption: _____

Additional Details: _____

Describe any home program that is currently performed (e.g. stretching, strengthening, brushing, etc):

Describe any community groups or sports activities the child is involved in: _____

Grade in School: _____ Name of School: _____

Does your child have an IFSP: Yes No

Does your child have an IEP from school? Yes No

Has your child had a psychological or neuropsychological evaluation completed? Yes No

Therapy Services	Type (Individual/Group)	Status (Ongoing/Discontinued)	How Often?	Where?
Assistive Technology				
Audiology				
Behavior Therapy				
EI Services				
Vision Therapy				
Nutrition				
Occupational Therapy				
Physical Therapy				
Social Therapy				
Speech/Language Therapy				
Developmental Follow-up Clinic				
Other:				

Additional Comments: _____

For Office Use Only:

- Developing age appropriate skills which were previously undeveloped or keeping functions which are at risk of being lost
- Improving, restoring, or adapting functional mobility or skills
- None of these apply

- Cognitive Impairment
- Neurological condition

Designated Individuals Authorization

I, _____, hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my child's treatment, payment or administrative operations related to treatment and payment. Without authorization, information will not be released. Also, I authorize the following people to pick up my child from physical or occupational therapy.

Authorized Designees:

Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____

I have read and understand the above consents, release of information, and designated individuals' authorization above.

Patient Name: _____ Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____