KINETIC EDGE PHYSICAL THERAPY

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

- ☐ Anemia of Prematurity
- ☐ Bronchopulmonary Dysplastia 'BPD
- ☐ Cleft Lip
- ☐ Cleft Palate
- ☐ Club Foot
- ☐ Cytomegalovirus
- ☐ ECMO
- ☐ Failure to Thrive
- ☐ Hyperbilirubinemia
- ☐ Intrauterine Growth Retardation 'IUGR'
- ☐ IVH Bleed Grade: _____
- ☐ Other: _____
- ☐ Jaundice
- ☐ Meconium Aspiration
- ☐ Necrotizing Enterocolitis 'NEC'
- ☐ Neonatal hypoxia
- ☐ Oxygen dependency
- ☐ PDA
- ☐ Positive dependency
- ☐ Respiratory Distress Syndrome
- ☐ Respiratory Syncytial Virus 'RSV'
- ☐ Retinopathy of Prematurity 'ROP'
- ☐ Thrombocytopenia (Low platelet count)
- ☐ Ventilator Dependency
- ☐ 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:		
Name:	**Specialty:**	**Reason:**

Does the child have:

- ☐ Allergies
- ☐ Arteriovenous malformation (AVM)
- ☐ Anoxic brain injury
- ☐ Asthma/respiratory breathing problems
- ☐ Autism
- ☐ Baclofen Pump
- ☐ Cerebral Palsy (CP)
- ☐ Cerebral Vascular Accident (CVA)
- ☐ Chronic Ear Infections
- ☐ Colic
- ☐ Constipation
- ☐ Diarrhea
- ☐ Down Syndrome
- ☐ Hip subluxation
- ☐ Hydrocele
- ☐ Laryngomalacia
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Periventricular Leukomalacia
- ☐ Reflux
- ☐ Scoliosis Degrees? _____
- ☐ Seizure Condition
- ☐ Sleep disorder
- ☐ Sleep problems
- ☐ Shunts
- ☐ Torticollis
- ☐ Traumatic brain injury (TBI)
- ☐ Tube Feeding
- ☐ Tubes in ears
- ☐ Vagal Nerve Stimulator
- ☐ 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:

Zipping/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)

☐ Birth mother _____ ☐ Step-mother _____

☐ Birth father _____ ☐ Step-father _____

☐ Adoptive mother _____ ☐ Grandmother _____

☐ Adoptive father _____ ☐ Grandfather _____

☐ Legal guardian _____ ☐ Other relative _____

☐ Foster mother _____ ☐ 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				
El 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: _____