Date _____
Competed by _____

Welcome to Edward Pediatric Rehabilitation Services!

Please complete the following sections of this form to help us better serve you and your child.

What name do you wish therapist to call your child _____

Child's Diagnosis: _____

Primary Reason for Therapy _____

Next appointment with doctor _____ Doctor's name _____

Follow up appointments scheduled with referring doctor _____

What are your/ your child's goal(s) for therapy? _____

When did this condition start? _____

Events leading up to this diagnosis (i.e. difficult delivery, motor vehicle accident, surgery , hospitalization, etc):
_____
_____

Please check any diagnostic tests your child has had:
___ x-ray ___ CT Scan ___ MRI ___ MRA ___ Myelogram ____ EMG other:_____

Do you know the results of the above tests? Yes/no
_____

Is your child scheduled for any of the above tests in the near future? _____

Child's Past Medical History (please include any surgeries):
_____
_____

Birth and Prenatal History:

Were there any complications during this pregnancy or delivery? If so, please describe in detail:
_____
_____
_____
_____

What type of delivery? C-section or normal spontaneous (circle one)
Expected Due date: _____
Length of pregnancy: ___ weeks Length of Labor: ___ hours
Birth weight: ___ pounds ___oz

Did your child have sucking or swallowing difficulties?_____ Feeding difficulties? _____
Was your child in the Neonatal Intensive Care Unit (NICU)? Yes/no
how long?_____ Discharge Date _____

Developmental History:
What age was your child able to hold up his/her head while on stomach? _____
What age did your child begin to roll over? _____ belly to back/ back to belly
What age did your child sit alone ? _____

Date _____

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What age did you child begin to crawl? _____
What age did your child pull to stand on his/her own? _____
What age did your child walk unaided? _____
What age did your child begin to babble? _____ speak words: _____
Child's current weight _____ & height _____
Does your child prefer right or left hand? _____
Does your child fall or lose his/her balance easily? _____
How often does your child fall? _____

Has your child ever received any physical, occupational or speech therapy services prior to this?
___ YES ___ NO
Does your child receive any of the above services at school?_____

If "YES", please describe:
_____
_____

Social History:

Who lives with the child? _____

House or apartment? _____

How many stairs does your home have? _____

Are there handrails to use with these stairs? Yes/no 1 or 2 rails?_____

Do you have any pets? _____

How many brothers and/or sisters does your child have? _____ Ages? _____

Does your child take any medications? (List all prescription and over the counter medications):
_____
_____

Does your child have any food or environmental allergies? (If "YES", please list (i.e. latex, peanut etc and note the type of reaction that occurs):
_____
_____

What are your child's interests:
_____
_____

What are your child's dislikes:
_____
_____

Please use the space below to provide any other information that you feel is important to your child's care:
_____
_____
_____

Therapist Signature _____