

# PEDIATRIC MEDICAL HISTORY

Child's Name: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Emergency Contact Name and Number: \_\_\_\_\_

Current Medications and Dosages: \_\_\_\_\_

History of main complaint (describe present injury/illness, treatment received, and surgery if any):

What functional difficulties has your child experienced because of this? \_\_\_\_\_

Does your child have any dietary restrictions? \_\_\_\_\_

Has your insurance been billed for any therapy (physical, occupational, and/or speech) services during this calendar year? Yes No If Yes, where were these services provided and approximately how many visits were billed? \_\_\_\_\_

What grade is your child in and what school do they attend? \_\_\_\_\_

Is therapy received in school? Yes No

Does your child have/had any of the following conditions, ( X any that are applicable):

Epilepsy/Seizures\_\_\_\_\_ Radiation Treatment\_\_\_\_\_ Hepatitis/Jaundice \_\_\_\_\_ Fainting \_\_\_\_\_

Cancer\_\_\_\_\_ Anemia\_\_\_\_\_ Heart Murmur \_\_\_\_\_ Leukemia \_\_\_\_\_

Hay Fever/Allergies\_\_\_\_\_ Tuberculosis\_\_\_\_\_ Diabetes\_\_\_\_\_ Asthma \_\_\_\_\_

Liver Disease\_\_\_\_\_ Other: \_\_\_\_\_

Has your child had any major surgical procedures in the past 5 years? If yes, please list: \_\_\_\_\_