

PRIMARY THERAPY SOURCE ◆◆◆ PEDIATRIC HEALTH HISTORY

Child's Name Last _____ First _____ Middle Init _____

Birth Date _____ Male Female Infant: Preterm Full Term

SSN _____ Day Phone _____ Cell Phone _____

Address _____ City _____ ST _____ Zip _____

Parent or Responsible Party _____

If different than minor's: Phone _____ Primary Language _____
Address _____ Second Language _____

Social Parents are Married Separated Divorced Single Widowed

Child lives with _____

Does child have siblings? No Yes If yes, no# & ages _____

Was this child one of a multiple birth? No Yes, indicate Twins Triplets Quads Quints

Are there stairs in the home? No Yes Do you have transportation? No Yes

Reasons for Therapy:

Please indicate if birth mother had any of the following problems during pregnancy:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Pre-eclampsia | <input type="checkbox"/> Excessive weight gain | No# pounds gained _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dehydration | |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Premature Labor | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Edema | <input type="checkbox"/> High Blood Pressure | _____ |

How many pregnancies did birth mother have? _____ How many live births? _____

- | | | |
|----------------------|--|--|
| Did the birth mother | <input type="checkbox"/> Take drugs that were prescribed? | <input type="checkbox"/> Smoke during pregnancy? |
| | <input type="checkbox"/> Take over-the-counter drugs during pregnancy? | <input type="checkbox"/> Drink alcohol during pregnancy? |

Does the child have:

Vision impairment? No Yes Hearing impairment? No Yes
If yes, describe: _____ If yes, describe: _____

Family History Are there any other family members with similar problems? No Yes
If yes, describe: _____

Birth History Where did the birth take place? Hospital Home Birthing Center
 Other, please explain _____

Type of Delivery Vaginal C-Section Did the baby present breech? No Yes
Were forceps used? No Yes Was vacuum extraction used? No Yes

Baby's Birth Length:	Baby's APGAR Score:	How long was baby in hospital? Was baby in NICU?
Baby's Birth Weight:	Did Baby Need Ventilator Support	How long was mother in the hospital?
Please indicate any diagnostic tests the baby/child has had:		
Medications	Prescription:	
	Over-The-Counter	

Please Check as Applicable	No	Yes	Describe
Respiratory Problems			
Seizures			
Muscle Spasms			
Falls			
Head Injury			
Loss of Consciousness			
High Fevers			
Heart Problems			
Shunt Placement			
Dehydration			
Abnormal Bleeding and/or Bruising			
Abnormal Growth			
Failure to Thrive			
Loss of Weight			
Diabetes			
Thyroid Dysfunction			
Urinary or Bowel Problems			
Gastrointestinal			
HIV			
Wheezing/Coughing during/after activity			
Agitation			
Excessive Sleeping			
Allergies			
Other			

Development Age of Child: _____ Child's Development: Normal Delayed Explain:

Recent Weight Changes No Yes Weight Gain _____ Weight Loss _____ Explain:

General Nutrition:

Feeding Difficulties? Explain:

Please indicate any other information that may be important or that you wish to discuss:

The above information is accurate and true to the best of my knowledge, and I give my consent for the evaluation to be performed.

Signature of responsible party if patient is a minor _____ Date _____

Printed Name _____ Relationship to Child _____