Pediatric Physical Therapy, Inc.

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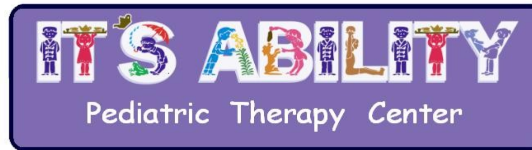


124 Hall Street, Suite H Concord, NH 03301

Phone: 603-224-4540 Fax: 603-228-7384

Dear Parent/Guardian,

Please fill out this form prior to coming to your child's initial therapy examination.

It is helpful for parents to fill out this information ahead of time so they can think carefully about the answers. History taking without a health history form can be difficult at the first appointment as children often are very eager to play and have a hard time sitting still while parents answer many questions. Of course, your therapist will still speak with you regarding your child's history. This form is simply designed to speed up the process and insure that your child's therapist has a complete understanding of your child's health. Furthermore, we strongly encourage you to bring copies of any pertinent medical or school records (i.e. IEP, evals, etc.) to your child's initial examination.

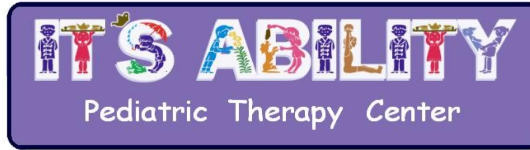
Thank you for choosing us for your child's therapy needs.

Sincerely,

Pediatric Physical Therapy, Inc. Staff

Pediatric Physical Therapy, Inc.

at



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HEALTH HISTORY FORM

Patient's Last Name	Patient's First Name	Date of Birth
Primary Care Physician/Pediatrician	Who referred you to physical therapy?	
Other doctors and healthcare providers involved in your child's care:		

STRENGTHS AND GOALS

1) Please list your child's strengths. Feel free to list anything that comes to mind. For example, kindness, ball skills, reading, etc.

____

____

2) Please list the goals you would like physical therapy to work on with your child.________________________

____

____

SOCIAL HISTORY

1) Who does your child live with? ❑Mother ❑Father ❑Sibling(s) ❑Grandparent(s) ❑Pet(s) ❑Other(s):________________
2) Who are the child's legal guardians? ____
3) Please list siblings and ages:____
4) Does your child attend school/daycare? ❑Yes ❑No If yes, what grade and what school/daycare? ______________
5) Does your child have friends? ❑Yes ❑No Please explain:____________________________
6) Do you feel your child displays appropriate social interactions and/or behaviors for his/her age? ❑Yes ❑No ❑Other:_________
7) Does your child participate in any recreational activities? ❑Yes ❑No If yes, please list:____________________
8) Does your child participate in any group classes outside of school/daycare? ❑Yes ❑No If yes, please list:__________

DEVELOPMENTAL HISTORY

Is/was your child able to do the following?	**Please Mark**	**If yes, what age did this ability emerge?**
Sit Independently	❑Yes ❑No ❑N/A	
Crawl or Creep Independently	❑Yes ❑No ❑N/A	
Walk Independently	❑Yes ❑No ❑N/A	
Walk with an assistive device	❑Yes ❑No ❑N/A	
Walk with the assistance of an adult	❑Yes ❑No ❑N/A	
Use a wheelchair	❑Yes ❑No ❑N/A	

BIRTH AND EARLY DEVELOPMENT HISTORY

Was your child born ❑Full Term ❑Premature(early):_______ ❑Postmature(late):_______ ❑Via normal delivery ❑Via C-section

Did your child spend time in the NICU and/or a special care nursery? ❑Yes ❑No If yes, please explain_____________________

Was/Is your child breastfed? ❑Yes ❑No ❑Combination of breast milk and formula If yes, for how long?____________________

PRESENT AND PAST HEALTH HISTORY

PRESENT AND PAST HEALTH Does or did your child have any of the following?	**Please Circle**	**Parent/Guardian Comments**	**Physical Therapist's Use Only**
Frequent Ear Infections	Yes / No		
Hearing Problems	Yes / No		
Ear Conditions	Yes / No		
Vision Problems	Yes / No		
Eye Conditions	Yes / No		
Skin Problems	Yes / No		
Swallowing Problems	Yes / No		
Cognitive Problems	Yes / No		
Emotional Problems	Yes / No		
Behavioral Problems	Yes / No		
High Blood Pressure	Yes / No		
Low Blood Pressure	Yes / No		
High Heart Rate	Yes / No		
Low Heart Rate	Yes / No		
Heart/Cardiac Conditions	Yes / No		
Heart Murmur	Yes / No		
Blood Disorder	Yes / No		
Unusual or Easy Bruising	Yes / No		
Lung Conditions	Yes / No		
Breathing Problems	Yes / No		
Asthma	Yes / No		
Lymphatic Conditions	Yes / No		
Kidney or Bladder Conditions	Yes / No		
Reflux	Yes / No		
Stomach Problems	Yes / No		
Digestive Problems	Yes / No		
Intestinal Problems	Yes / No		
Diarrhea	Yes / No		
Constipation	Yes / No		
Metabolic Conditions	Yes / No		
Oral Motor Problems	Yes / No		
Sensory Problems	Yes / No		
Sleep Problems	Yes / No		
Dental Problems	Yes / No		
Growth Problems	Yes / No		
Fine Motor Problems	Yes / No		
Gross Motor Problems	Yes / No		
Broken Bone(s)	Yes / No		
Strains or Sprains	Yes / No		
Head Injury, TBI or Concussion	Yes / No		
Cancer	Yes / No		
Other	Yes / No		

PAIN:

1) Does your child have pain? ❑YES ❑ NO ❑ UNSURE ❑OTHER:____

2) If your child does have pain, please answer the following:

  a. When does your child have pain? (check all that apply) ❑Morning ❑Day ❑Evening ❑Night ❑Other:________________

  b. How often does your child have pain? _________________Please Explain______________________________________

  c. Where does your child experience pain? ____

  d. What makes your child's pain worse and/or causes the pain? ____

  ____

  e. What makes your child's pain better and/or stops the pain?____

  ____

3) Has your child ever experienced pain during physical therapy (i.e. pain with stretching, walking, etc.)? ❑YES ❑ NO ❑ N/A

GENERAL HEALTH HISTORY

1) Please describe any allergies (i.e. food, medications, latex) your child has:____

____

____

2) Has your child been prescribed epinephrine (i.e. Jr. EPI-PEN) and/or an anti-histamine (i.e. Benadryl)? ❑Yes ❑No ____________

3) Have you ever been told that your child is under-weight? ❑Yes ❑No ____

4) Have you ever been told that your child is over-weight? ❑Yes ❑No ____

5) Has your child recently had unexplained weight loss or gain? ❑Yes ❑No If yes, please describe___________________________

6) Is your child up to date on all recommended vaccinations? ❑Yes ❑No If no, please explain_____________________________

MEDICATIONS, VITAMINS, SUPPLEMENTS, ALTERNATIVE MEDICATIONS and HOMEOPATHIC MEDICATIONS

Please list all medications, vitamins and supplements including alternative and homeopathic medications that your child is taking.

Medication, vitamins, etc.	Dose	Taken how often?	Medication, vitamins, etc.	Dose	Taken how often?

-

SURGICAL HISTORY

Please list any surgeries your child has had with the dates they were performed (approximate dates are fine).

Surgery	Date	Surgery	Date

EQUIPMENT AND ORTHOTIC HISTORY

Please list any equipment (wheelchair, walker, bath chair, lift, hospital bed, etc.) and any orthotics (AFOs, Back Brace, etc.) that your child has with the approximate date this equipment/orthotic was obtained in addition to the vender/orthotist:

Equipment/Orthotic	Date Obtained	Vender/Orthotist	Equipment/Orthotic	Date Obtained	Vender/Orthotist

____ ______________________________ ____________

Person Completing This Form/Relationship to Patient   Reviewed by Physical Therapist   Date