Connections Pediatric Therapy
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CONNECTIONS
PEDIATRIC THERAPY

Adolescent Health History

Today's date:_____

IDENTIFYING INFORMATION:

Child's name: _____

Date of birth: _____ Age: _____ Yrs. _____ Mos. Sex: M F

School: _____

Grade:_____

Parent names:_____

Stepparents involved:_____

Child lives with:_____

Other family members (list ages and in/out of home):

Biological siblings:_____

Step siblings:_____

Others:_____

Primary language spoken in home:_____

REASON FOR REFERRAL:

Referred by: _____

Reason for visit: _____

When was the reason first noticed? _____

By whom? _____

Diagnosis (list type and dates): _____

Previous evaluations (list type and dates): _____

Current/previous therapy (list type and dates): _____

Current Medications (list dosage):_____

_____

What are your concerns about your child?_____

What do you hope will be gained by having your child seen at this clinic?

_____

_____

_____

MEDICAL CONTACTS:

Pediatrician: _____ Group or practice: _____

Other physicians or therapists:_____

Name:_____ Group or practice:_____

Name: _____ Group or practice:_____

Name: _____ Group or practice:_____

PREGNANCY/BIRTH HISTORY:

Please describe any significant pregnancy or birthing experiences:

_____

_____

_____

CHILDHOOD MEDICAL HISTORY:

Check any of the following that apply. List age and explanation:

Item	**Check if "Yes"**	**Age**	**Explanation**
Regular Medications (please list)			
Convulsions/seizures			
Meningitis			
Encephalitis			
Injury to head			
Fainting spells			
Measles			
Chronic illnesses			
Constipation			
Reflux			
Allergies			
Chronic Cough			
Asthma			
Heart disorders			

Item	Check if "Yes"	Age	Explanation
Stomach or intestinal disorders			
Reactions to immunizations (specify)			
Chronic ear infections			
Hearing exam/poor hearing			
Vision exam/poor eyesight			
Sleep disorders			
Eating disorders			
Hospitalizations (give details)			
Other			

FAMILY HISTORY:

Check any of the following that apply. List relationship (i.e. mother, brother), and explanation:

Family History of...	Check if "Yes"	Family History	Explanation
Learning Disorders			
Emotional Disorders			
Genetic Disorders			
Attention Disorders			
Speech/Language Disorders			
Substance Abuse			
Other			

MOTOR DEVELOPMENT:

Please describe any significant motor development delays or any treatment/therapy received:

_____

_____

_____

SPEECH AND LANGUAGE DEVELOPMENT:

Please describe any significant speech, language, eating delays or behaviors as well as any treatment/therapy received: _____
_____

ACADEMIC/EDUCATION DEVELOPMENT:

School: _____ Phone:_____
Address:_____
Grade:_____ Teacher:_____
Most liked subjects:_____
Least liked subjects:_____
Future Goals/Plans: _____

History:

Schools Attended	Years

Check any of the following that apply:

Academic Behaviors	**Check all that apply**	**Academic Behaviors**	**Check all that apply**
Poor physical coordination		Word problems and calculations	
Poor handwriting, letter formation		Poor spelling in day-to-day assignments	
Poor memory, short-term and long-term		Problems with classwork or homework completion	
Right-left confusion, directionality problems		Procrastinates	
Hand dominance established late (_____age) or not at all		Forgets assignments/materials	
Late letter recognition		Poor attention and concentration	
Poor word recognition skills		Conflict with teachers	
Poor reading comprehension		Trouble keeping materials organized	

Academic Behaviors	Check all that apply	Academic Behaviors	Check all that apply
Poor phonetic base		Certified for special education (LD resource help, MR, Speech, etc.)	
Poor reading comprehension		Drop in group achievement tests	
Difficulty getting ideas on paper		Repeated grade — please list which grade(s):	
Problems in math		Expulsion/suspension from school	

SOCIAL/EMOTIONAL BEHAVIORAL DEVELOPMENT:

Who generally disciplines the child? _____

What methods are used: _____

Do parents agree on methods of discipline? Yes No

If no, describe: _____

_____

_____

Check any of the following that apply:

Behaviors	Check all that apply	Explanation
Difficulty sleeping ☐ and/or Nightmares ☐		
Enuresis (wetting) ☐ and/or Encopresis (soiling) ☐		
Sucks Thumb		
Difficult to discipline		
Temper tantrums		
Sad ☐ and /or Cries easily ☐		
Unusually active, fidgety ☐ and/or Bites nails ☐		
Unusually inactive, apathetic		
Difficulty with brothers and/or sisters		
Difficulty in getting along with other children		
Lacks age appropriate play skills		
Socially inappropriate		

Behaviors	**Check all that apply**	**Explanation**
Avoids peer interactions or other unfamiliar social contacts		
Inattentive ☐ and/or Impulsive ☐ and/or Distractible ☐		
Unrealistic worry and/or pessimistic attitude		
Anxiety ☐ and/or Separation anxiety ☐		
Panic attacks		
Difficulty with transitions		
Resists changes in environment		
Blames others for own mistakes		
Expresses no remorse		
Lies ☐ and/or Steals ☐		
Truant ☐ and/or Excessive absenteeism ☐		
School refusal		
Disregards family or community rules		
Argumentative		
Destructive		

Additional comments: _____

_____

_____

_____

Please note any major changes in your child's family, school, social life in the last 6–9 months, which could be important. If there is any specific information which has not been requested on this form but which would help us in understanding your child's problems, please include here:

_____

_____

_____

_____

_____

_____

_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you for taking the time to complete this form. It will help us serve your family better. If you have other critical documentation related to your concerns, please bring copies of records to your next appointment.