Connections Pediatric Therapy
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CONNECTIONS
PEDIATRIC THERAPY

School Age Medical Health History

Today's date:_____

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:

Check any that apply. List age that your child achieved this skill:

Skill	Age	Skill	Age
Smiled		Bowel Trained	
Followed with eyes		Went to bathroom alone	
Reached for objects		Undressed him/herself	
Rolled over		Dressed him/herself	

Skill	Age	Skill	Age
Sat without support		Used buttons, zippers, and snaps	
Crawled		Skipped	
Pulled to stand		Rode tricycle	
Stood without support		Used eating utensils	
Walked alone		Used writing utensils	
Bladder Trained		Used scissors	

SPEECH AND LANGUAGE DEVELOPMENT:

Describe VERBAL BEHAVIOR: _____

_____

_____

_____

Can you understand your child's speech? Yes No Can others? Yes No

Does your child stutter? Yes No

If yes, describe:_____

Estimate vocabulary size: 0 words 1-25 words 25-50 words 50-100 words over 100 words

Describe LISTENING BEHAVIOR: _____

_____

_____

Can your child follow 3-step directions? Yes No

Can your child answer complex questions? Yes No

Can your child tell about past events or experiences? Yes No

EATING/SWALLOWING BEHAVIORS:

Describe typical foods/liquids consumed at:

Breakfast:_____

Lunch: _____

Dinner: _____

Quantity of liquids consumed per day: _____

What does your child drink from? (sippy cup, cup, etc.) _____

How does your child eat? (spoon-fed, finger foods, spoon, fork, adaptive equipment)

_____

Does your child have a good appetite? Yes No

Is your child a picky eater? Yes No

Does your child choke frequently? Yes No

Does your child drool? Yes No

Does your child refuse any food tastes, textures, or temperatures? Yes No
If yes, describe: _____
_____
_____
_____

ACADEMIC/EDUCATION DEVELOPMENT:

School: _____ Phone:_____
Address:_____
Grade:_____ Teacher:_____
Most liked subjects:_____
Least liked subjects:_____

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		

Behaviors	Check all that apply	Explanation
Avoids peer interactions or other unfamiliar social contacts		
Socially inappropriate		
Inattentive ☐ and/or Impulsive ☐ and/or Distractible ☐		
Anxiety ☐ and/or Separation anxiety ☐		
Difficulty with transitions		
Resists changes in environment		
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.