



PEDIATRIC PATIENT INFORMATION

DATE: _____

NAME OF CHILD: _____ Sex: _____

DOB: _____

Form filled out by: _____ Relationship to patient: _____

Referred by: _____

Primary Physician and Clinic: _____

Other Physicians/specialists that are involved in your child's care:

Name _____ Clinic _____ Phone # _____ Fax # _____

Name _____ Clinic _____ Phone # _____ Fax # _____

Name _____ Clinic _____ Phone # _____ Fax # _____

FAMILY HISTORY:

Parent(s)/Legal Guardian: _____

Phone Number: Home _____ Work _____ Cell _____ E-mail _____

Child lives with: ___ 1 parent ___ 2 parents ___ Other Adults in Home _____

Siblings and Ages: _____

Primary Language: _____ English: Spoken Y/N Understood Y/N Interpreter needed? Y/N

Religious/cultural needs: yes no _____

Emergency Contacts:

Name	Home Phone	Work Phone	Cell Phone

BIRTH HISTORY:

At what week of pregnancy was your child born? _____

Any unusual occurrences during pregnancy/delivery? yes no If yes, explain: _____

MEDICAL HISTORY:

Diagnosis/Main Concern (describe): _____

First Noticed: _____

Current Medications and reason for taking: _____

Past Medical History (i.e. seizures, hospitalizations, fractures, chronic ear infections, Botox/Phenol injections, scoliosis etc.): _____

Surgical History: _____

Do you have any concerns about your child's swallowing/feeding/eating/nutrition? yes no

If yes, explain: _____

Has hearing been checked? yes no If yes, when: _____

Where: _____ Results: _____

(over)



MERCY & UNITY
HOSPITALS
Allina Hospitals & Clinics

Sister Kenny® Rehabilitation Institute

Mercy Hospital
4050 Coon Rapids Blvd.
Coon Rapids, MN 55433
763-236-8908
Fax: 763-236-8930

Patient Name, Social Security #, Date of Birth

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OT / PT / SLP

Has your child's vision been checked? yes no If yes, explain: _____

Where: _____ Results: _____

Does your child have any allergies/food allergies? yes no If yes, explain: _____

During treatment food or candy is occasionally used. May we give your child food and/or candy?
 yes no Special diet needed? yes no If yes, explain:

Has your child had a positive CMV (cytomegalovirus) test? yes no

Past and current medical equipment (i.e., braces, splints, walkers, wheelchair, communication device, etc.):

DEVELOPMENTAL HISTORY: *At what age did your child:*

Hold head up: _____	Walk with help: _____	Babble and Coo: _____
Reach for objects: _____	Walk alone: _____	Use single words: _____
Sit alone: _____	Feed self: _____	Use groups of words: _____
Crawl: _____	Dress self: _____	Use sentences: _____
Stand: _____	Become toilet trained: _____	

Child's current abilities (i.e., rolling, sitting, crawling, feeding, etc.): _____

How do you communicate with your child? How does your child communicate with you? (list examples) _____

EDUCATION (Special Ed, OT, PT, Speech/Language Treatment, etc.):

School/District: _____

Present Case Manager/Therapist/Teacher: _____

Is there a current IFSP/IEP? yes no Date of next review: _____

Current School Programming/Services: _____ Current Schedule: (# of minutes/week)

ADDITIONAL SERVICES (past and/or current therapy services, behavioral services, etc.):

List any evaluations or private therapy services your child has received / is receiving:

Agency	Type of Therapy	Dates Followed

GENERAL BEHAVIOR:

Does your child:

Sit and listen for long periods? yes no _____

Follow verbal directions? yes no _____

Engage in any self injurious activities? yes no Please explain: _____



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Have favorite play activities? (List) _____

Did your child start talking/babbling and then stop? yes no _____

What are your child's strengths? _____

What are your child's most frequent behavior concerns? _____

How are these concerns best resolved? _____

How is your child best calmed when upset? _____

Please circle the number that best describes your child's pain for this condition.

(0 = no pain, 10 = severe pain)

0 1 2 3 4 5 6 7 8 9 10

How much pain do you consider a tolerable or acceptable level for your child?

0 1 2 3 4 5 6 7 8 9 10

Would you like to have more information about:

- Child Development
- Financial Assistance
- Family Support Groups
- Mobility Equipment
- Communication Devices
- Other: _____
- Speech/Language Development
- School Services (0-21 years of age)
- Respite Care
- Assistive Technology

What goals would you and your child like addressed during therapy?

Mercy and Unity Hospitals are concerned with each individual's emotional and physical safety. Do you have concerns for your child in this area? yes no

Please list the names of family, friends, or PCAs who may be involved in your treatment here.

NAME	AGE	RELATIONSHIP

Preferred learning style: Reading Listening Demonstration Audio/Visual
Parent/Child (circle one)

Staff use only: Parent/Child	Barriers: R/R L/L V/V H/H P/P F/F C/C S/S E/E CL/CL N/N
	Readiness: W/W N/N R/R A/A <u> </u> / <u> </u>

Will your child be utilizing a ride service to attend therapy sessions? yes no

If yes, please list company name and phone number:

Ride Service Name	Phone Number

* Please note:



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