PEDIATRIC MEDICAL HISTORY FORM:

Child's Name: ____DOB:____________**Age**:___________
Parent's Name:_________________________________**Siblings**:_____________________________
Pediatrician:______________________________**Referring MD**:___________________________
Other Specialists (neuro,ortho, developmental)_______________________________________

Reason for Referral:____
____
Other Concerns:____
Goals for PT:____

Birth History: Pregnancy: How many weeks?____
Any unusual stress during pregnancy?____
Any complications during pregnancy?____

Delivery complications?(forceps, suction, position)___________________________________
Type of delivery(C-section, vaginal)____
Post Natal: Birth weight______________________length________________APGARS:_________
Any complications post natally?____

Feeding: Breast fed:________________bottle fed:_______________________pacifier:_________

Medical/ Surgical History: ____
____

Illness/ Condition	**Frequency**	**Treatment/ Date**
Ear Infection/ Tubes		
Tonsils/ Adenoids		
Seizures		
Allergies		
Asthma		
Fevers/ Colds		
Severe Falls		
Heart Disease		
Chicken Pox		
Measles, Mumps, Pertussis		
Constipation		
GERD		
Concussion		

History of Torticollis/ Plagiocephaly: ____
Medications:____
Allergies:____

Hearing Tested?____
Vision Tested?____

Developmental Milestones:

Milestone	**Age Achieved**	**Not yet Achieved**	**Comments**
Rolling belly-back			
Rolling back-belly			
Sitting alone			
Crawling			
Standing			
Walking alone			
Babbling			
Toilet training			

Has your child ever received early intervention services?____________________________
Name of school/ daycare____
Primary caregiver during the day____

What 3 words would you use to describe your child?___________________________________

Anything else that you feel is important for us to know to best help your child?____

How were you referred to our office?____