Northfield Hospital + Clinics

Medical History – Pediatric Rehabilitation

Patient name: _____ Date of Birth: _____ Date: _____

Parents Name(s): _____

Parents Phone Number(s): _____

Premature ❑ Yes ❑ No If yes, how many weeks? _____ Height_____ Weight_____ Sex_____

Main Concern

What is the main concern? _____

What activities are limited by this condition? _____

What do you expect to accomplish with therapy? _____

What is your insurance company's name? _____

History of current injury/illness (pertinent to this current diagnosis): (Please check those that apply)

❑ Physical Therapy? .....When?.....❑ 0-1 years ago.....❑ 1-5 years ago.....❑ 5 years plus

❑ Occupational Therapy? .....When?.....❑ 0-1 years ago.....❑ 1-5 years ago..... ❑ 5 years plus

❑ Speech Therapy? .....When?.....❑ 0-1 years ago .....❑ 1-5 years ago.....❑ 5 years plus

❑ Chiropractor?.....When?.....❑ 0-1 years ago.....❑ 1-5 years ago.....❑ 5 years plus

What was done? _____

❑ Injections: When? _____ Where? _____ Did it help? ❑ Yes ❑ No

❑ X-ray_____ ❑ MRI_____ ❑ CT scan _____

❑ Surgery: When? What kind? _____

❑ School services ❑ Yes ❑ No What services? _____

Medications

❑ Blood thinner ❑ Muscle Relaxants ❑ Sleeping aids
❑ High blood pressure ❑ Pain relievers ❑ GERD medications
❑ Anti-seizure ❑ ADD/ADHD medication ❑ Allergy medication
❑ Other: _____

Has the patient ever been diagnosed with any of the following?

	Yes	No		Yes	No		Yes	No
Tuberculosis			Cancer			Arthritis		
Diabetes			Hepatitis			Food Allergy		
Depression			Metal Implants			Latex Allergy		
Heart Condition			Epilepsy			Sulfite Allergy		
Hypertension			Respiratory Problems			Other Allergy		
Pacemaker			Special Diet					
			What type of diet?	_____				

In case of emergency whom should we notify? _____

Phone number for emergency contact _____

Therapist's signature_____ Date_____