PEDIATRIC MEDICAL DATABASE

Identifying Information

Today's Date: _____

Child's Name:_____ Date of Birth:_____Age:_____ Gender: F M

Name of person filling out this form: _____

Parent/Guardian Name(s):_____

Home Phone:_____ Cell Phone:_____

Work Phone: _____ Email: _____

Address:_____ Town:_____ Zip:_____

Primary Physician:_____ Primary Physician Phone Number:_____

Referring Physician:_____ Referring Physician Phone Number:_____

Birth History

Length of pregnancy _____ Type of Delivery _____

Difficulties during pregnancy/labor/delivery: Y N If yes, please explain:

_____

_____

Were drugs and/or alcohol used during the pregnancy? Y N If yes, please explain:

_____

_____

Birth weight: _____pounds _____ounces

Developmental History

Developmental History Please indicate at what age your child achieved the following milestones: *Mark N/A for those which your child has not achieved yet or if not relevant to current evaluation

Rolled over	_____	Babbled	_____
Sat alone	_____	Said first word	_____
Crawled	_____	Drank from a cup	_____
Pulled to stand	_____	Fed him/herself	_____
Stood alone	_____	Toilet trained	_____
Walked alone	_____	Dressed self	_____

Attention span for self-directed activities? _____

Attention span for adult-directed activities? _____

Medical History

Current diagnosis with date of onset (for which you are seeking therapy):_____

Past Medical History (including accidents, surgeries, other diagnoses, etc.): _____
_____
_____

Has your child had previous therapeutic assessments? Y N If yes, please describe (include where and when): _____
_____
_____

Has your child had any other specialized assessments (i.e. psychological, behavioral, neurological, etc)? Y N If yes, please describe (include where and when): _____
_____
_____

Does your child have any precautions to therapy (previous fractures, previous surgeries, seizures, trach, G-tube)**:** Y N If yes, please explain: _____
_____
_____

Does your child have any allergies? Y N If yes, please describe: _____
_____
_____

Current Medications:_____
Previous Medications: _____

Has your child had ear infections? Y N If yes, when:_____
Has hearing been formally tested? Y N
If yes, when was testing completed?_____
If yes, where was testing completed?_____
What were the results?_____
Were tubes placed? Y N If yes, when, where and by whom? _____

Any vision difficulties? Y N If yes, please explain: _____
Does your child wear glasses? Y N
If yes, state reason_____

Does your child have any past or current feeding difficulties (i.e. sucking, swallowing, chewing, etc) ? Y N If yes, please explain: _____
_____
_____

Does your child use any adaptive equipment or orthotic devices? Y N If yes, please explain: _____
_____
_____

Caregiver Concerns

Please describe the main concerns for which you are seeking therapy: _____
_____
_____

How long have you had these concerns? _____
_____
_____

Have there been any changes to the concerns over time? Y N If yes, please explain: _____
_____
_____

What is your child's reaction to the concerns? _____
_____
_____

How does the family react to the concerns? _____
_____
_____

What are your family's goals for therapy? _____
_____
_____

Social and Educational History

What languages are spoken at home?_____

Please list the family members your child lives with (siblings, parents, grandparents, pets, etc.):_____
_____

Please describe your child's day care, educational and/or play settings:_____
_____

Does your child currently have an IFSP, IEP, or 504 Plan? Y N If yes, please describe services below:

- Birth to Three Services: PT OT SLP Other: _____
  - Frequency and duration of services: _____
- School Based Therapy: PT OT SLP Other: _____
  - Frequency and duration of services: _____

Has your child received therapeutic services in the past? Y N If yes, please discuss type, location, frequency and duration below:

_____
_____

What are your child's favorite toys, hobbies, interests, etc.?_____

Does your child have any behavioral problems? Y N If yes, what strategies have you found to be effective for behavior management?

_____

_____

Is there any additional information that would assist us in providing care to your child (likes, dislikes)?

_____

_____

Emergency Contact: List someone other than the person who regularly brings your child to therapy:

Name: _____ Relationship to Client: _____ Phone:_____

A copy of your child's evaluation will be sent to his/her referring physician and pediatrician. Additional copies of the evaluation will be provided upon request.
Please initial here to indicate that you are aware of this procedure: _____

By signing below, you are acknowledging that the information in this form is accurate.

_____ _____
Signature **Date**

_____
Relationship to patient

Thank you for completing this form, as it will greatly enhance your child's evaluation process. Please return it to CFZ prior to evaluation via email, fax, or mail to give the evaluating therapist ample time to review your child's information.

We look forward to working with you and your child!

Cheshire and Meriden evaluations
Fax: 203-699-9641
Email: Forms@CheshireFitnessZone.com
Mail: 382 South Main St., Cheshire, CT 06410

Orange evaluations
Fax: 203-920-1881
Email: Forms@CheshireFitnessZone.com
Mail: 308 Racebrook Rd., Orange, CT 06477