Pediatric Center
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INFANT PEDIATRIC THERAPIES: PT, OT, SLP

FAMILY AND MEDICAL HISTORY FORM

Please complete this history form. The information provided will help us in determining the best course of therapy your child. If you have any questions please discuss them with your child's therapist. Thank you.

General Information:

Patient name: ____ Date of Birth: ____________________

Parent names: ____

Who is your child's pediatrician? ____

What are your primary concerns regarding your child? _______________________________________

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When did you first have these concerns? ____

____

What languages are spoken in the home or day care? ____

Others living in the household:

NAME	SEX/AGE	RELATIONSHIP TO CHILD	HEALTH STATUS

Family Medical History:

Is there a family history of any genetic, congenital or familial medical conditions? If so, please list condition and relationship to patient:____

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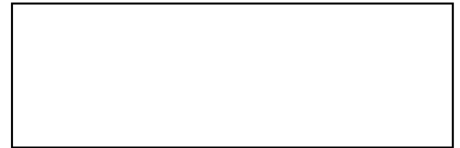

Prenatal History:

Did you have any of the following events occur during this pregnancy? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, what occurred, how treated etc):

NO	YES	DESCRIPTION	EXPLANATION
		Allergies or asthma	
		Anemia	
		Diabetes/blood sugar problems	
		Edema (swelling, water retention)	
		Excessive vomiting	
		Headaches/migraines	
		Heart disease	
		Kidney disease	
		Pre-eclampsia	
		Rh negative	
		Toxemia	
		Toxin exposure	
		Accidents	
		Bleeding/spotting	
		Blood transfusions	
		Cervical incompetence	
		Infections (bladder or genital)	
		Infections (other)	
		Pre-term labor	
		Uterine or uterine fluid problems	
		Other physical injury	
		Other not specified problem	
		Use of medications (over the counter and prescribed)	

Labor, Delivery and Birth History (for this patient):

Length of pregnancy: ______________________ Length of Labor (in hours): ______________________

Any type of labor stimulation, and what was used? ____

What type of delivery (please circle)? Vaginal Cesarean Section = elective or emergency

Presentation: Head, Face, Breech, Transverse Reason for C-section ____________________________

Assistance: Forceps, Vacuum, other ____

Were there any other problems during the labor/delivery/birth? ___________________________________

What were the baby's APGAR scores? 1 minute _________________ 5 minutes ______________________

What was the baby's birth weight? _________________ Length? ____________________________________

Number of Days spent in the nursery: ______________ NICU or Newborn Nursery? _____________________

Did you experience any of the following problems during the labor/delivery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (why, what occurred, how treated etc):

NO	YES	DESCRIPTION	EXPLANATION
		MATERNAL infection	
		Low/high red/white blood cell count	
		Pelvis or cervical problems	
		Placenta problems	
		Dysfunctional labor	
		Baby had the cord around the neck	
		Cord problems (knots, prolapsed, compression)	
		Baby had very low or high heart rate	
		Baby had heart rate decelerations	
		Fetal distress was noted	
		Meconium was noted	

Nutritional History:

Describe your child's feedings briefly from birth, noting any difficulties (breast/bottle fed, colic/food allergies, introduced solids/table foods, growth/nutrition problems, feeding problems) ____

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Did/Does your child use a pacifier? ____

Medical History of the Child:

It is very important to have as complete a medical history for your child as possible. Please check the first column if your child has experienced any of these conditions, include an explanation for any questions answered yes. In your explanation please include your child's age(s) if relevant, any diagnoses made and any treatments that have occurred.

YES	DESCRIPTION	EXPLANATION
	Frequent Colds/Respiratory Illness	
	Frequent Strep throat/sore throat	
	Tonsil and or adenoid removal	
	Frequent Ear Infections	
	Hearing Loss/Ear disorder	
	Myringotomy tube placement	
	Lung condition/respiratory disorder	
	Allergies or asthma	
	Heart condition	
	Anemia/blood disorder	
	Kidney/ Urinary problems/infections	
	Hormonal problem	
	Muscle disorder/muscle problem	
	Joint or bone problems/Fractured bones	
	Skin disorder/skin problems (eczema)	
	Vision problems/Eye infections	
	Neurological disorder	
	Seizures or convulsions	
	Stomach disorder/stomach pain	
	Vomiting/digestion problems	
	Failure to gain weight/feeding problems	
	Constipation/diarrhea problems	
	Dehydration episodes	

	Head injuries or concussions	
	Ingestion of toxins, poisons, foreign objects	
	Any communicable diseases (CMV, MRSA, HIV, etc)	
	Any major childhood illness (pox, croup, measles, mumps, meningitis, Fifth's disease, etc)	

Hospitalizations, Surgeries and/or Accidents:

List the dates of any hospitalizations, surgeries, and/or accidents your child has had and the reason: ___________________

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____

Please note any illnesses for which your child is currently being treated, **including medications**: _____________________

____

____

Does your child have any known allergies? If so, please list: ____

____

Motor Developmental History:

We would like to have information about your child's developmental milestones. Indicate the age when your child first did each of the following INDEPENDENTLY. If you cannot remember a specific age, please indicate if your child completed this milestone at an age greater or lesser than approximate age listed. If your child has not yet achieved the milestone, write N/A in the age column.

MILESTONE	On time (age range)	Late	MILESTONE	On time (age range)	Late
Smiled	≤ 2 mos		Threw objects actively	≤ 16 mos	
Held head up sitting	≤ 3-5 mos		Ate independently with a spoon/fork	≤ 2.3 years	
Rolled both ways	≤ 6 mos		Dressed self	≤ 4 years	
Reached for an object actively	≤ 5 mos		Caught a thrown object	≤ 26 mos	
Transferred object between hands	≤ 7 mos		Demonstrated handedness (which?)	≤ 5.5 years	
Sat unsupported	≤ 9 mos		Rode bicycle without training wheels	≤ 9 years	
Crawled	≤ 10 mos				
Stood alone	≤ 13 mos		Bladder trained - days	≤ 3 years	
Walked independently	≤ 15 mos		Bladder trained - nights	≤ 3 years	
Ran	≤ 18 mos		Bowel trained	≤ 3 years	

Hearing Testing:

Do you feel that your child hears adequately? ____________________

Has your child had a hearing screening? If so when and where? ____________________

Has you child had a hearing evaluation by an audiologist? If so, please specify when and where:____________________

What were the results? ____________________

Speech and Language Milestones

MILESTONE	On Time (age range)	Late	EXAMPLE
Babble	≤ 4-6 mos		
Gesture/Signs	≤ 9-12 mos		
Jargon/Jibber-jabber	≤ 12-15 mos		
Imitates sounds/words	≤ 9-12 mos		
Participates in song/finger plays	≤ 9-12 mos		
Said first word (please give an example *other than Mama/Dada*)	≤ 7 mos		
Combined 2 words together	≤ 2 yrs		
Combined 3+ words together	≤ 2 ½- 3yrs		
Followed single-step directions	≤ 12-15 mos		
Followed multi-step directions	≤ 21- 24 mos		
Knew body parts	≤ 15-18 mos		

Behavioral Presentation:

Circle the traits that describe your child as an infant:

Cried a lot　Fussy　Irritable　Non-demanding　Alert　Quiet

Passive　Active　Liked being held　Resisted being held　"Floppy"　Tense

Good sleeping pattern　Irregular sleeping patterns

Other descriptions or information regarding your child as an infant:____________________

____

Please list any other services or Specialists your child currently is followed by:

Specialist	Focus	Phone Number	Contact (yes/no)?

To the best of my knowledge, this information that I have provided is accurate and complete.

____________________　____________________

Signature of Parent or Guardian　**Date**

____________________　____________________

Therapist Signature　**Date**

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