PEDIATRIC HISTORY FORM
Confidential

Identifying Information:

Child's Name:		Date:
Age:	Sex:	Birth Date:
Mother: email:		Home Phone: Mother Cell:
Father: email:		Father Cell Phone:
Address:		Appointment Reminder: Phone Call Text Email
Insurance Plan: Primary Insurance Holder: Insurance Holder Social Security No: Member ID Number: Group Number: *found on front of ins. card (copy of ins. card required at first visit)		Insurance Provider Phone Number: Pre-certification Phone Number: Customer Service Phone Number: Eligibility and Benefits Phone number: Mail Claims to Address: *found on back of ins. card
Name of Person Completing This Form: Relationship to Child:		

Nature of the Problem / Any Diagnosis (Describe your child's problem as fully as possible):
Services Requested: PT OT SLP

Family Information

Mother's Occupation: Education: Age: Speech, Language or Learning Related Problems?	Father's Occupation: Education: Age: Speech, Language or Learning Related Problems?
Child lives with: Σ both parents; Σ father; Σ mother; Σ other	
Children in the family:	
Family History of speech, language or learning related problems with siblings?	

Child's Development --Birth History

Mother's health during pregnancy:	
Pregnancy duration:	Birth weight:
Special Considerations: Σ Prolonged Σ Induced Σ Breach Σ Caesarean Σ Twin (1st/2nd) Σ Premature	
Baby's health (color, jaundice, bruises, breathing problems, incubator, abnormalities, feeding):	

Hearing:

Do you think that your child has a hearing problem? If yes, explain:		
Has your child's hearing been tested? **Y/N** **Findings: normal/abnormal**	By whom?	
Tubes in ears:	Date inserted:	Date removed:

Vision

Have child's eyes been examined? **Y/N** **Findings: normal/abnormal**	Wear glasses? **Y/N**	By whom?

Motor Development

At what age did your child:			
Sit without support		Walk Independently	
Crawl		Gain Bladder and Bowel control	
Check any that apply:			
Trips easily		Climbs poorly	
Afraid of climbing		No Fear	
Clumsy with hands		Runs into things	
Any other motor concerns?			
Any concerns with biting, drinking, chewing, or swallowing? (Please explain):			

Speech and Language Development

What were child's first words: Examples:					Age:
How many words can your child say? about 1-10 10-50 50-100 100-300 300-500 Over 500					
What percent of the time is the child's speech understood by:					
Mother	Father	Brothers & Sisters	Friends	Teachers	Other relatives
Does your child customarily communicate by use of: Gestures Pantomime Sounds One or two words Phrases Complete sentences					
Did your child have their tonsils/adenoids removed? If yes, when?					
Does your child understand and/or speak another language other than English? Which is the predominant language at home? If yes, explain:					
Was there ever a time when our child's speech and language skills regressed or he/she stopped talking? When? Describe the circumstances:					

Health/Neurological History

Child's physician:	Phone:	Address:
Other Physicians:		
Date of Last Physical Exam:		
Current Medications: (Name, Dosage, Reason)		

Has your child had a neurological exam? When?	For What Reason?
Name, Address, Telephone of Neurologist:	
Is child receiving any physical, occupational, and/or speech/language therapy now? **Y/N** Why?	Where:
Does your child have an IFSP? First Steps services? YES NO 0-3 years of age	What services do/did they receive? PT OT SLP
Does your child receive IEP services in school? YES NO 3 to 21 years old/school-based services	What services do/did they receive? PT OT SLP

Medical Background

Are there any conditions Therapeutic Playtime should be aware of that your child has undergone treatment for? Please describe: