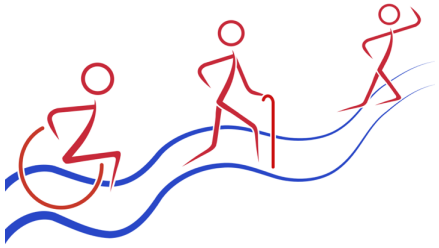
Grand River Rehabilitation

Serving adults & children with pain & disabilities



New Patient History Form (Pediatric)

Name _____ DOB _____ Sex _____
Reason for visit _____

Physicians

Primary Care (PCP) _____ Orthopaedist _____
Neurologist _____ Physiatrist _____
Pulmonologist _____ Urologist _____
Eye Dr _____ ENT _____
Neurosurgeon _____ Dentist _____
Orthotist/Prosthetist _____ Other Physician _____

Allergies (food, medication, latex) _____

Medication	Dose	Frequency	Medication	Dose	Frequency

Past Medical History

Immunizations up to date? ☐ Yes ☐ No Flu vaccine? ☐ Yes ☐ No
Please explain missed immunizations: _____

Any chronic diseases or conditions (i.e. cerebral palsy, hydrocephalus, spina bifida, seizures, asthma, diabetes, heart disorder, etc.)? _____

Has the patient ever had a concussion, traumatic brain injury, spinal cord injury, meningitis, encephalitis, hearing or vision loss, or other conditions impacting functioning? _____

Please list all surgeries, with approximate dates: _____

Any other medical problems? _____

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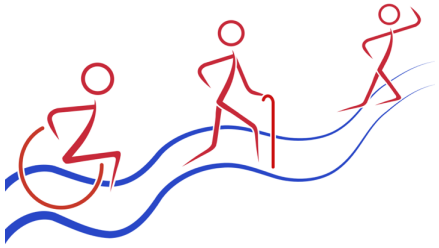

Patient's Birth History

How many times has patient's mother been pregnant? _____ Where is patient in birth order? _____
Difficulties with other pregnancies (i.e. miscarriage, prematurity, still birth)? _____
Mother's health before pregnancy? _____
Were drugs/alcohol/tobacco used during pregnancy (if yes, please explain) _____
Mother's age at pregnancy _____ Duration of pregnancy (in weeks)
Pregnancy complications _____ Length of labor (hours) _____
Delivery: ☐ Vaginal ☐ Feet first ☐ Buttocks first ☐ Forceps ☐ C-section (reason) _____
Birth weight _____ Apgar scores 1min _____ 5min _____

Was resuscitation required at birth? _____ How long was child hospitalized? _____
Any problems at birth or before going home? _____

Social History

Father's name _____ Age (now) _____
Employment, Level of education _____
Mother's name _____ Age (now) _____
Employment, Level of education _____
Child's primary caregiver _____
People living in home _____

Siblings name	Age	Siblings name	Age

Hours of daycare (per day) _____ Provider _____

Patient's Educational/Therapeutic History

School _____ Grade (or highest attended) _____
Working at grade level? _____ Accommodations or Special Education? _____
Last psychology testing _____ Last IEP/504 _____

Frequency of therapies

	School	Private
Speech therapy		
Physical therapy		
Occupational therapy		
Other		

Assistive devices used (splints/braces/cane/walker/wheelchair/etc) _____

Best means of mobility: ☐ Orthotics (braces) ☐ Walk with assistance ☐ Crutches ☐ Walker ☐ Wheelchair (manual/powered) ☐ Other _____
Best means of communication _____

Please bring braces, crutches, walker, wheelchair, communication devices, etc. to every appointment.

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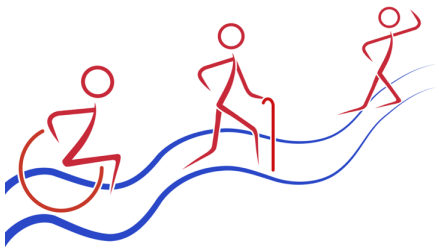

Independence with self-care (*I: Independent, P: Partially independent, U: Unable*)

Feed self with fingers	I	P	U	Drink from cup	I	P	U	Toilet self	I	P	U
Feed self with utensils	I	P	U	Wash face/hands	I	P	U				
Dress self	I	P	U	Bathe self	I	P	U				

Family (*not* personal) History

	No	Yes (specify diagnosis & relative)
Sudden death of young person		
Tuberculosis (TB)		
HIV		
Sickle cell		
Bleeding problems		
Seizures		
Anxiety/depression		
Migraine/cluster		
Chronic pain disorder		

	No	Yes (specify diagnosis & relative)
Learning problems (ADHD, dyslexia, etc.)		
Muscle disorder		
Fibromyalgia		
Neurologic disorder		
Spina bifida		
Cerebral palsy		
Genetic disorder		
Other		

Developmental History (age at which child could):

Hold head up _____ Pull to stand _____ 2-3 word phrase _____
Rollover purposefully _____ Walk alone _____ Bowel trained _____
Sit alone _____ Climb stairs _____ Bladder trained _____
Crawl _____ Say first words _____

Person filling out form:

_____ _____
Signature Relationship to patient

_____ _____
Name Date/time