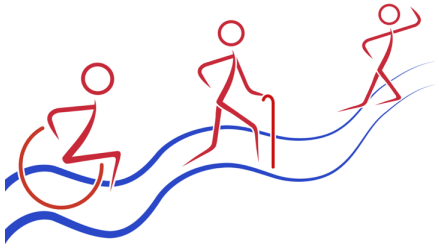
Grand River Rehabilitation

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 _____
Preferred Pharmacy _____

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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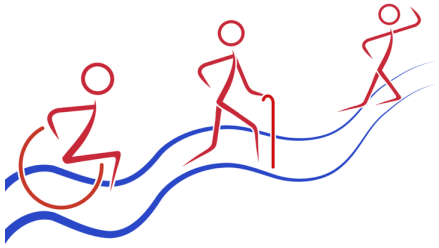

Patient's Birth History

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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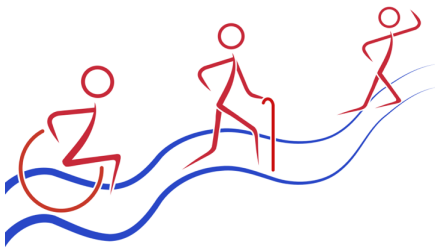

Independence with self-care (*I: Independent, P: Partially independent, U: Unable*)

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

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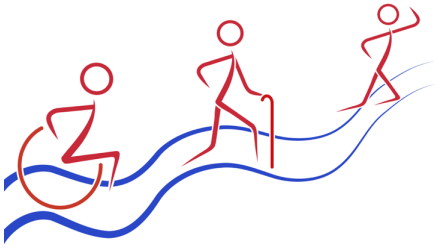

Review of Systems (check any that apply to you ***currently or within the last 2 weeks***):

Constitutional

Fever	
Night sweats	
Weight loss	
Weight gain	
Chills	
Exercise intolerance	
Fatigue	

Eyes

Dry eyes	
Vision changes	
Irritation/ Redness	
Double vision	
Eye injury	

Respiratory

Cough	
Wheezing	
Shortness of breath	
Coughing up blood	
Snoring	

Ear, Nose, Throat

Difficulty hearing	
Ear pain	
Nosebleed	
Sinus problems	
Sore throat	
Bleeding gums	
Dry mouth	
Mouth ulcers	
Teeth problems	
Ear ringing	

Cardiovascular

Chest pain	
Arm pain	
Palpitations	
Heart murmur	
Ankle swelling	

Gastrointestinal

Abdominal pain	
Nausea	
Vomiting	
Changes in appetite	
Diarrhea	
Acid reflux	
Constipation	

Muskuloskeletal

Muscle aches	
Muscle weakness	
Joint pain	
Back pain	
Neck pain	
Difficulty walking	
Muscle cramps	
Osteoporosis	
Fracture(s)	

Neurologic

Loss of consciousness	
Stroke	
Weakness	
Numbness	
Seizures	
Dizziness	
Headaches	
Tremor(s)	
Abnormal gait	
Paralysis	

Miscellaneous

Depression	
Sleep disturbances	
Behavioral problems	
Alcohol abuse	
Anxiety	
Hallucinations	
Suicidal thoughts	
Mood swings	
Memory loss	
Irritability	