Patient Name:_____ DOB:_____ Date:_____

**Edwards & Associates Physical Therapy Pediatrics History Form**

**Dear Parent: This is a health questionnaire on your child. Please complete this form. Bring it with you at the time of an appointment.**

**Contact Information for Parent 1**

Name:_____ Email:_____

Home Address: _____

Home Phone:_____Work Phone:_____ Cell/Other:_____

**Contact Information for Parent 2**

Name:_____ Email:_____

Home Address:_____

Home Phone:_____ Work Phone:_____ Cell/Other:_____

This child lives with: Mother Father Mother/Father Mother/Partner Father/Partner Grandparent/Other

MIT Affiliation

Person: Position: Department:

**FAMILY HISTORY**

1. Parent 1 Age:_____ Current Health:_____
   Past Health Problems:_____
2. Parent 2 Age:_____ Current Health:_____

Past Health Problems:_____

3. Marital Status of Parents:_____
4. Other Children in Family:

| Date of Birth | Gender | Name | Healthy or Medical Issues? |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**PRENATAL HISTORY**

1. While pregnant, did mother have:
   a. Bleeding or spotting_____no yes
   b. German measles (Rubella)_____no yes
   c. Gestational diabetes_____no yes
   d. High blood pressure_____no yes
   e. Illness other than cold/flu_____ no yes
   f. Kidney disease_____ no yes
   g. Premature labor_____no yes
   h. Threatened miscarriage_____no yes
   i. Toxemia_____no yes
2. Were medications or herbs taken during pregnancy? _____no yes
   If yes, what kind:_____
3. Was a fertility treatment used for this pregnancy?_____ no yes
   If yes, what kind:_____

Patient Name:_____ DOB:_____ Date:_____

**BIRTH HISTORY**

1. Where was child born:_____
2. Was labor induced?_____ no yes
3. Was labor helped by medication?_____ no yes
4. Duration of labor:_____
5. Was child born early (less than 38 weeks)?_____ no yes
6. Was child born late (after 42 weeks)?_____no yes
7. What was the method of delivery:
   - Breech
   - Caesarean (Please state reason): _____
   - Forceps
   - Spontaneous vaginal
8. Child's birth weight: _____
9. Apgar Score (if known): _____
10. During the hospital stay, did child have any of the following:
    a. Antibiotic treatment_____ no yes
    b. Blue spells_____ no yes
    c. Convulsions_____ no yes
    d. Jaundice_____ no yes
    e. Skin rash_____ no yes
    f. Did child remain in hospital longer than mother?_____ no yes
11. How was/is baby fed?
    - Bottle
    - Breast

**DEVELOPMENTAL HISTORY:**

1. At what age did child: Age
   a. Hold up head _____
   b. Roll over _____
   c. Sit unsupported _____
   d. Stand alone _____
   e. Walk _____
   f. Talk _____
   g. Toilet train _____
   h. Feed him/herself _____
   i. Dress him/herself _____

**PAST MEDICAL HISTORY:**

**1. Has the child had:**

a. Blood: anemia (iron deficiency, Sickle Cell, Thalessemia)_____ no yes
b. Blood transfusions_____ no yes
c. Chicken pox (Varicella)_____ no yes
d. Contusions_____ no yes
e. Convulsions_____ no yes
f. Fractures_____ no yes

Patient Name:_____ DOB:_____ Date:_____

g. German Measles (Rubella)_____ no yes

h. Hospitalizations_____ no yes

i. Measles (Rubeola)_____ no yes

j. Meningitis_____ no yes

k. Mumps_____ no yes

l. Operations_____ no yes

If yes, what illness?

m. Poison ingestion no yes

n. Other serious medical illnesses no yes

If yes, what kind?

o. Is your child currently taking any medications, vitamins or herbs? no yes

| Medication | Strength/Dose | How Often? | Reason |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

p. Reaction to medication or food (allergy) no yes

If yes, please explain:

q. Any chronic or recurring pain? no yes

If yes, please explain:

**2. Eyes:**

a. Any visual problems?no yes

b. Do eyes look crossed? no yes

c. Does the child wear eyeglasses? no yes

**3. Ears:**

a. Any hearing problems? no yes

b. Three or more ear infections? no yes

**6. Heart:**

Have you ever been told your child has

a. A heart murmur? no yes

b. Heart defect? no yes

c. High blood pressure?no yes

**7. Lungs:**

Has your child ever had

a. Asthma/wheezing? no yes

b. Bronchitis or pneumonia? no yes

c. Chronic cough? no yes

**8. Does your child tire easily?** no yes

**9. Abdomen**

Has your child ever had

a. Blood in bowel movement? no yes

b. Difficulty with appetite or eating? no yes

c. Frequent abdominal pain? no yes

d. Frequent vomiting or diarrhea? no yes

e. Jaundice? no yes

f. Marked weight loss? no yes

If yes, please explain:

Patient Name:_____ DOB:_____ Date:_____

**10. Kidney:**

a. Does your child ever complain of burning or frequency of urination? no yes
b. Does your child wet the bed? no yes
c. Has there ever been blood in the urine? no yes
d. Has your child ever had a urinary tract infection? no yes

**12. Extremities:**

Has your child

a. Had weakness or paralysis of arms or legs? no yes
b. A persistent limp? no yes
c. Every worn corrective shoes or braces? no yes

**13. Neurological:**

Has your child ever had

a. Breath holding? no yes
b. Convulsions or seizures? no yes
c. Dizziness? no yes
d. Fainting? no yes
e. Frequent headaches? no yes
f. Temper tantrums? no yes

**14. Is your child:**

a. Impulsive? no yes
b. Lacking in self-control? no yes
c. Overactive? no yes
d. Does your child have problems with:
   i. Attending school? no yes
   ii. Attention span? no yes
   iii. Learning? no yes
   iv. Mood? no yes
   v. Parents? no yes
   vi. Peers? no yes
   vii. Siblings? no yes
   viii. Sleep? no yes

16. Any other concerns you would like to discuss?

_____
_____
_____

_____ _____ _____ _____

Parent Signature Date Provider Name Date Reviewed