



# Pediatric Therapy Partners

PHYSICAL THERAPY • OCCUPATIONAL THERAPY • SPEECH-LANGUAGE THERAPY

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## **FAMILY AND MEDICAL HISTORY FORM**

### **PART 1-GENERAL INFORMATION**

CHILD'S FULL NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

### **COMPOSITION OF FAMILY IN WHICH CHILD CURRENTLY RESIDES (Primary Caregivers)**

FATHER'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

RELATIONSHIP TO CHILD (please circle one): Biological    Adoptive    Step    Foster    Other: \_\_\_\_\_

### **OTHER PERSONS LIVING IN THIS CHILD'S HOUSEHOLD:**

NAME	SEX	AGE	RELATIONSHIP TO THE CHILD
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**FAMILY STRESSORS** (please note/explain if any of the following stressful events happened in the last 12 months):

ITEM	NO	YES	EVENT	EXPLANATION
1			Marital separations/divorce	
2			Death in the family	
3			Financial crisis	
4			Job change/difficulties	
5			School problems	
6			Legal problems	
7			Medical problems	
8			Household move	
9			Extended separations from parents	
10			Other stressful event(s)	

**PRENATAL HISTORY:**

1. Did you have any problems getting pregnant? Please describe: \_\_\_\_\_

2. Please list all over the counter medications taken during this pregnancy and when (e.g. Vitamins, antacids, cold medications, aspirin, etc): \_\_\_\_\_

3. Please list any cigarettes, caffeine, street drugs taken (how much a day and when in pregnancy): \_\_\_\_\_

4. Please list all prescription medications taken (name, dosage and from when to when): \_\_\_\_\_

5. Please give in pounds, the amount of total weight lost and /or gained during this pregnancy: \_\_\_\_\_

6. 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.):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Allergies or asthma	
2			Anemia	
3			Diabetes/blood sugar problems	
4			Edema (swelling, water retention)	
5			Excessive vomiting	
6			Headaches/migraines	
7			Heart disease	
8			Kidney disease	
9			Pre-eclampsia	

10			Rh negative	
11			Toxemia	
12			Toxin exposure	
13			Accidents	
14			Bleeding/spotting	
15			Blood transfusions	
16			Cervical incompetence	
17			Infections (bladder or genital)	
18			Infections (other)	
19			Pre-term labor	
20			Uterine or uterine fluid problems	
21			Other physical injury	
22			Other not specified problem	

**BIRTH HISTORY (for the child being evaluated):**

1. Hospital where born + city + state: \_\_\_\_\_

2. Physician's Name: \_\_\_\_\_

3. Gestational Age at time of delivery (or # weeks early or late): \_\_\_\_\_

4. Length of Labor (in hours)? \_\_\_\_\_ Length of membrane rupture? \_\_\_\_\_

5. Any type of labor stimulation and what was used? \_\_\_\_\_

6. Any type of pain medication or anesthesia used during delivery (name, type, amount if known)?

Pain relief \_\_\_\_\_ Anti-vomiting \_\_\_\_\_

Sedation \_\_\_\_\_ Anesthesia \_\_\_\_\_

7. 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 \_\_\_\_\_

8. 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):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Maternal infection	
2			Low/high red/white blood cell count	
3			Pelvis or cervical problems	
4			Placenta problems	
5			Dysfunctional labor	
6			BABY had the cord around the neck	
7			Cord problems (knots, prolapsed, compression)	
8			Baby had very low or high heart rate	
9			Baby had heart rate decelerations	
10			Fetal distress was noted	
11			Meconium was noted	

9. How soon after the delivery did you see your baby? \_\_\_\_\_

10. What were the baby's APGAR scores? 1 minute \_\_\_\_\_ 5 minutes \_\_\_\_\_

11. What was the baby's Birth Weight? \_\_\_\_\_ Birth Length \_\_\_\_\_



**PART 3: MEDICAL HISTORY OF CHILD**

It is very important to have as complete a medical history for your child as possible. Please fill out the grid below, making sure you include an explanation for any question answered 'yes'. In your explanation, please include your child's age(s) if relevant, any diagnoses made, and any treatments that have occurred.

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Frequent Colds/Respiratory Illness	
2			Frequent Strep throat/sore throat	
3			Frequent Ear Infections (?tubes)	
4			Birth defect/genetic disorder	
5			Lung condition/respiratory disorder	
6			Allergies or asthma	
7			Heart condition	
8			Anemia/blood disorder	
9			Kidney/renal disorder	
10			Urinary problems/infections	
11			Hormonal problem	
12			Muscle disorder/muscle problem	
13			Joint or bone problems	
14			Fractured bones	
15			Skin disorder/skin problems (eczema)	
16			Visual disorder/vision problems	
17			Eye infections	
18			Neurological disorder	
19			Seizures or convulsions	
20			Stomach disorder/stomach pain	
21			Vomiting/digestion problems	
22			Failure to gain weight/feeding problems	
23			Constipation/diarrhea problems	
24			Dehydration episodes	
25			Hearing Loss/Ear Disorder	
26			Significant accidents	
27			Head injuries or concussions	
28			Ingestion of toxins, poisons, foreign objects	
29			Major medical procedures (detail below)	
30			Chronic medications (for what? When?)	
31			Any major childhood illness (pox, croup, measles, mumps, meningitis etc)	

**HOSPITALIZATIONS AND/OR SURGERIES:**

List the dates of any hospitalizations your child has had and the reason. List the dates of any surgeries your child has had and the reasons.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**PRESENT HEALTH STATUS:** Most recent height= \_\_\_\_\_ Weight= \_\_\_\_\_ Date \_\_\_\_\_

Please note any illnesses for which your child is currently being treated, including their Current Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1. Do you feel your child was 'faster' or 'slower' than his/her peers in any other way? Please explain  
\_\_\_\_\_
2. If your child is in school, please describe any difficulties or strengths in reading, writing or spelling:  
\_\_\_\_\_
3. Name of previously attended school: \_\_\_\_\_ Grades: \_\_\_\_\_
4. Name of current school: \_\_\_\_\_ Grades: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Any special education services (which, when)? \_\_\_\_\_  
Teacher: \_\_\_\_\_  
Describe any other concerns shared by the teacher: \_\_\_\_\_
5. Has your child had problems with any of the following (beyond expected for child's age):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Sleeping problems	
2			Bed wetting	
3			Drooling	
4			Thumb sucking	
5			Temper tantrums	
6			Head banging	
7			Breath holding	
8			Aggression/destructiveness	

9			Nervous habits (nail biting etc)	
10			Masturbation	
11			Fire play or cruelty to animals	
12			Major mood swings	
13			Under or over reactive to sounds	
14			Under or over reactive to clothing	
15			Under or over reactive to taste	
16			Under or over reactive to smell	
17			Any unusual fears?	

### **FAMILY MEDICAL HISTORY**

Are there any of the following medical problems on either side of the child's BIOLOGICAL parents' families? If YES, please indicate on which side of the family, MOTHER or FATHER and explain WHO this is in relation to the CHILD. Please also explain if medications, surgery or hospitalizations were needed.

ITEM	NO	YES	DESCRIPTION	MOTHER'S OR FATHER'S SIDE	WHO?	EXPLANATION
1			Birth defects/Congenital disorder			
2			Neurological disorder or seizures			
3			Respiratory disease or tuberculosis			
4			Hormonal or Gland disorder			
5			Allergies-food or environmental (specific which for whom)			
6			Diabetes			
7			Stomach disease/disorder/problems			
8			Senses problems-vision, hearing, touch, taste, smell, balance			
9			Swallowing or feeding problems			
10			Attentional/learning problems			
11			Hyperactivity			
12			Alcohol/drug problems			
13			Psychological/nervous issues			