



LABEL

**PEDIATRIC / ADOLESCENT  
PATIENT INFORMATION RECORD**

MR # \_\_\_\_\_ Acct # \_\_\_\_\_

**GENERAL INFORMATION**

Patient Name \_\_\_\_\_ Sex:  M  F Date of Birth \_\_\_\_\_  
 Name of Parent/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_ Home/Work Phone \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_ Pediatrician/Primary Care Physician \_\_\_\_\_  
 Primary Language spoken \_\_\_\_\_ Means of Communication:  Verbal  Gestures  Sign  Picture boards  
 Religions or cultural practices that may effect the child's care:  No  Yes, explain \_\_\_\_\_

What is the problem that brings the child to therapy? \_\_\_\_\_

Is the child's problem due to:  Auto Accident, date \_\_\_/\_\_\_/\_\_\_,  Injury, date \_\_\_/\_\_\_/\_\_\_, describe \_\_\_\_\_  
 Unknown cause, date problem first noticed \_\_\_/\_\_\_/\_\_\_.

Prior therapy for this condition:  Inpatient Rehab, Where \_\_\_\_\_, When \_\_\_\_\_  Early Intervention  
 Outpatient Rehab, Where \_\_\_\_\_, When \_\_\_\_\_  School

Which of the following has the child had for the current problem?:

	Date	Results		Date	Results
<input type="checkbox"/> X-rays	_____	_____	<input type="checkbox"/> Genetic Testing	_____	_____
<input type="checkbox"/> MRI	_____	_____	<input type="checkbox"/> Swallow Study	_____	_____
<input type="checkbox"/> CT Scan	_____	_____	<input type="checkbox"/> Phenol Blocks	_____	_____
<input type="checkbox"/> EEG	_____	_____	<input type="checkbox"/> Botox	_____	_____
<input type="checkbox"/> EMG	_____	_____	<input type="checkbox"/> Other	_____	_____

**Known Allergies:** \_\_\_\_\_

**Dietary Restrictions:** \_\_\_\_\_

**CURRENT MEDICATIONS**

DRUG	DOSAGE/FREQUENCY	DRUG	DOSAGE/FREQUENCY

**MEDICAL/SURGICAL HISTORY**

	Yes	No		Yes	No		Yes	No
Chronic colds -Respiratory Infections			Psychiatric History / Emotional			Bowel or Bladder Problems		
Chronic Ear Infections			Pregnancy			Vision Difficulty		
Asthma			Lead Poisoning			Hearing Difficulty		
Recurring Pneumonia			Feeding Disorder			Autism / PDD		
Meningitis			Gastrointestinal Disorder			Down's Syndrome		
Encephalitis			Reflux			Cerebral Palsy		
Seizure Disorder			Thyroid Disease			Tourette's Syndrome		
Febrile Seizure			Diabetes			Congenital Disorder **Explain		
Stroke			Cancer			Injury -* Explain		
Joint Replacement			Sleeping Problems			**		

Major surgical procedure within the last 60 days (e.g., craniotomy, laminectomy)?  No  Yes \_\_\_\_\_

List Prior Surgeries/Hospitalization Dates \_\_\_\_\_



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MR # \_\_\_\_\_ Acct # \_\_\_\_\_

**CHILDHOOD DISEASES, IMMUNIZATIONS AND VACCINES**

Which of the following has the child had?  Measles  Chicken Pox  Mumps  Rubella  
Has the child been exposed to any of these in the past three weeks?  No  Yes Explain: \_\_\_\_\_

Immunization Schedule	Vaccine	Yes	No
Birth	Hep B		
2 Months	DTP or DtaP		
	Hep B		
	HiB		
	Oral Polio or IPV		
4 Months	DTP or DtaP		
	HiB		
6 Months	DTP or DtaP		
	Hep B		
	HiB		
	Oral Polio or IPV (optional dose)		
12 – 15 Months	MMR		
	TB		
	Varicella		
15 – 18 Months	HiB		
18 Months	DTP or DtaP		
	Oral Polio or IPV		
4 – 6 Years	DTP or DtaP		
	MMR		
	Oral Polio		
11 – 12 Years	MMR		
	Varicella		
	Td		
14 – 16 Years	Td (if not @ 11-12 years)		

**Parent / Guardian's Goals for Treatment**

\_\_\_\_\_

\_\_\_\_\_

Patient/caregiver unable to complete form; information reviewed and completed by therapist. \_\_\_\_\_ Initials \_\_\_\_\_

Name of Person Completing Form: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Clinician Signature/Title/Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Clinician Signature/Title/Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_