

**BRAINTREE REHABILITATION HOSPITAL
PEDIATRIC / ADOLESCENT
PATIENT INFORMATION RECORD**

MR # _____ Acct # _____

ADDRESSOGRAPH

GENERAL INFORMATION

Patient Name _____ Sex: M F Date of Birth _____
 Name of Parent/Guardian _____ Relationship _____ Home/Work Phone _____
 Pediatrician/Primary Care Physician _____ Phone # _____
 Address _____ State _____ Zip _____
 Primary Language spoken _____ Means of Communication: Verbal Gestures Sign Picture boards
 Computer with voice output Other _____
 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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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		
4 Months	Oral Polio or IPV		
	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 _____

In order to reach your optimum rehabilitation, it is essential that you follow your physician's prescribed treatment and the treatment plan established by your therapist.

If you must cancel an appointment, please notify us as soon as possible so that we can reschedule your missed appointment within the week. We appreciate notification of cancellations 24 hours prior to scheduled appointments; this allows us to utilize your appointment time for other patients.

We are obligated to record all cancellations and no shows in your medical record. If you are covered by worker's compensation, we are obligated to report cancelled and "no show" appointments to your insurance carrier.

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

Name of Person Completing Form: _____

Date: _____

Clinician Signature/Title/Initials _____

Date _____

Clinician Signature/Title/Initials _____

Date _____

Clinician Signature/Title/Initials _____

Date _____