EXETER HOSPITAL
5 Alumni Drive Exeter, NH 03833 603.778.7311
Pediatric Rehabilitation

Patient Case History

Patient Name _____ **Date of Birth** _____

GENERAL INFORMATION

Person completing this form: □ Parent(s) □ Guardian □ Foster Parent(s):_____

Email address: _____

How did you learn about our program? □ Physician □ Family □ Friend □ School □ Community Event

Specialists your child sees: _____ Specialty: _____ Phone: _____

_____ Specialty: _____ Phone: _____

Established diagnoses (List):

_____

Please describe your reasons for seeking services:

_____

_____

What do you want your child to be able to do that he/she is currently not able to do?

_____

_____

HEALTH INFORMATION

Current medications, alternative medical interventions and/or supplements:

_____ Reason: _____

_____ Reason: _____

Is your child experiencing any pain? □ Yes □ No If yes, is it: □ mild □ moderate □ severe □ Location _____

Please check any conditions that apply to your child's medical history:

□ Vocal nodules	□ Asthma	□ Head injuries / concussion	□ Glasses
□ Pneumonia	□ Frequent colds	□ Fractures	□ Swallow study
□ Ear infections	□ Meningitis	□ Hyperactivity	□ AFO's/braces
□ Ear tubes	□ Seizures	□ Reflux	□ Weakness
□ Cerebral hemorrhage	□ Heart problems	□ Craniofacial deformities	□ Snoring
□ Abnormal voice	□ Diabetes	□ Sleep difficulties	□ Failure to thrive

□ Other:_____

Please list any surgeries (Including dates and locations): _____

_____

Has your child's hearing been tested in the last 12 months? □ Yes–(within normal limits) □ Yes–(did not pass) □ No

Please describe any additional medical work-ups that have been completed in the last 6 months:

_____

_____

Please list any special equipment that your child requires (wheelchair, communication device, etc…):

_____

List any allergies: _____

Has your child started experiencing changes associated with puberty? □ Yes □ No

Patient Name _____ **Date of Birth** _____

PREGNANCY & BIRTH HISTORY

Please check any conditions that apply to pregnancy and/or birth history:

☐ premature ☐ late ☐ breech delivery ☐ cesarean section ☐ forceps delivery ☐ required oxygen

☐ neonatal intensive care unit ☐ jaundice ☐ required a feeding tube

Did/does your child have problems with: ☐ sucking? ☐ swallowing? ☐ drooling? ☐ breathing? ☐ other?

If yes, please describe: _____

_____

Birth weight: _____

FEEDING INFORMATION

Current type of diet: ☐ regular ☐ liquids ☐ puree ☐ chopped ☐ other : _____

How does your child eat or drink? ☐ breast-fed ☐ bottle ☐ cup ☐ sippy cup ☐ spoon/fork ☐ feeding tube

Does your child cough, gag or have increased congestion during or soon after meals? ☐ Yes ☐ No

Do you consider your child's diet to be limited by ☐ texture ☐ taste ☐ temperature

Describe: _____

Does your child eat less than 20 foods? ☐ Yes ☐ No

Please describe any concerns related to feeding or swallowing:

_____

MOTOR MILESTONES

Did your child achieve motor milestones as expected? ☐ Yes ☐ No (if no, check all that were delayed)

☐ tummy time greater than 15 min ☐ rolling ☐ sitting independently ☐ on hands and knees ☐ crawling

☐ cruising along furniture ☐ standing independently ☐ walking alone

Please describe motor concerns: _____

_____

Does your child primarily use his /her ☐ right hand? ☐ left hand? ☐ both hands?

Does your child have difficulty with any of the following: ☐ using utensils? ☐ tying shoes?

☐ holding a crayon or pencil? ☐ cutting with scissors? ☐ writing? ☐ using fasteners on clothes?

SELF HELP SKILLS

Does your child dress / undress independently? ☐ Yes ☐ No If no, what help does he/she need?

_____

_____

Does your child have difficulty with toileting activities (ie: clothing management, voiding, wiping)? ☐ No ☐ Yes

If yes, please describe: _____ _____

How does your child sleep? ☐ restful ☐ difficulty falling asleep ☐ restless ☐ nightmares ☐ wakes early

Does your child have difficulty completing grooming and/or hygiene activities (i.e.,: hand/face washing, brushing hair, nail clipping, etc.)? ☐ No ☐ Yes Describe: _____

Patient Name _____ **Date of Birth** _____

BEHAVIORAL INFORMATION

What activities does your child enjoy? (toys, puzzles, sports, games, characters, etc.)

_____

Describe any behavioral challenges exhibited by your child: _____

_____

Does your child seek out any of the following? (check all that apply)

□ rocking □ twirling □ jumping □ spinning □ biting □ repetitive activities □ head-banging □ crashing

Does your child appear: □ insensitive to pain? □ clumsy? □ distractible? □ aggressive?

EDUCATIONAL INFORMATION

What school/childcare does your child currently attend? _____ Grade _____

If daycare or preschool program, list days and times child attends: _____

Did/does your child receive additional support services? (check all that apply)

□ Early Intervention □ Special Education □ 504 plan □ Educational Aide □ OT, PT, Speech

□ Community-based services □ Family supports/services □ Behavioral interventions □ Counseling

Other: _____ _____

How does your child learn best? (check all that apply) □ hearing □ seeing □ doing

What is your child's readiness to learn and interact with others? □ excellent □ good □ fair □ poor

FAMILY INFORMATION

Caregiver Occupation(s): _____ _____

List the people now living in the household:

Name	Relationship to Child	Age

Parent / Guardian Signature: _____ Date _____

To be filled out by Rehabilitation Services

- ☐ I have verified, within the scope of my interview and assessment of the patient, that he/she is not experiencing difficulties related to sexual, physical or emotional abuse or neglect in the home.
- ☐ Therapist suspects there may be an identified abuse issue. Follow procedures outlined in (PE) policies in the Administrative Policy Manual

Therapist reviewing patient history Signature:_____ Date / Time:_____