kitsap physical therapy
AND SPORTS CLINICS

Outpatient Pediatric Health History

- **IDENTIFYING INFORMATION** **Today's Date: _____**

Name of Child: _____ Birth Date: _____
(first) (middle) (last)

Preferred Name: _____ Pronouns:_____
Age: _____

Gender Assigned at Birth:_____ Gender Identity:_____

Primary Care Physician: _____

Parent email address (es): _____

**** Please inform your child's therapist whenever there is a change in your diagnoses, medications, or if there have been any significant operative and/or invasive procedures performed.***

Child lives with: _____

Parents:	**Name**	**Age**	**Occupation**	**Level of Education**
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Caregiver/Guardian	_____	_____	_____	_____

If the address of either parent is different from that of the child, please indicate:
_____

Other children in the family:

Name	Sex	Age	Grade

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Have any siblings ever received PT, OT, or Speech therapy? ϒ Y ϒ N
If yes, please explain: _____
Do any family members have speech, language, hearing, learning, or physical development problems? ϒ Y ϒ N
If yes, please explain: _____

- **ALLERGIES:**
  - None

Please check mark any allergies that apply to your child and describe if indicated:

- Drugs _____ Reaction _____
- Foods _____ Reaction _____
- Latex _____ Reaction _____
- Other (i.e. metal) _____ Reaction _____

- **DRUG RESISTANT ORGANISM HISTORY**
  Does your child have a history of MRSA / VRE or Other Resistant Organism? Y N
  If yes, please list last date s/he tested positive: _____

- **MEDICATIONS**
  Does your child take any prescription or non-prescription medications for the current problem? Y N
  Current and/or past medications *Reason for taking*
  - _____
  - _____
  - _____
  - _____
  - _____

- **HOSPITALIZATIONS/SURGICAL HISTORY**
  Has your child ever been hospitalized? Y N
  Please list any significant hospitalizations that your therapist should know or that could affect your treatment
  _____ Date: _____
  _____ Date: _____
  Has your child ever had surgery? Y N

Please list any significant surgeries or invasive procedures that your therapist should know or that could affect your treatment

_____ Date: _____

_____ Date: _____

- **DEVELOPMENTAL HISTORY**

This child is my:

- biological
- adopted
- foster child
- other _____

If child is adopted or a foster child and you are unable to answer the questions in this section, please skip down to Section VII DEVELOPMENTAL MILESTONES

- **Pregnancy**

How many pregnancies has the mother had? _____

Which pregnancy was this child? _____

Mother's age at the time of this pregnancy: _____

Please list any complications with this child's pregnancy: _____

Any medical problems prior to this pregnancy? _____

If yes, please describe: _____

Did the mother take any prescription and/or nonprescription drugs during pregnancy? ____

If yes, what kind(s)? _____

- **Delivery**

This child was born:

- full-term
- Premature (How early? _____)

Child's delivery was:

- vaginal
- Caesarean (Was it an emergency? _____)

Was mother given any drugs during labor or delivery? _____ If so, what kind(s)?

_____

Please list any complications with this child's delivery:

_____

_____

- **After Delivery**

Please list any complications for this child after delivery? _____

_____

_____

How long were the mother and child in the hospital? _____

Weight of child at birth: _____

- **DEVELOPMENTAL MILESTONES**

Please indicate the approximate age at which your child:

Rolling tummy to back _____ Rolling back to tummy _____
Sitting independently _____ Army crawling _____
Hands and knees crawling _____ Walking _____
Running _____ Babbling _____
First words _____ Bladder trained _____
Bowel trained _____ Night bladder/bowel trained _____

Any concerns regarding gross motor skills (e.g. walking up/down stairs, running, jumping, etc)? _____
Any concerns regarding fine motor skills (e.g. stacking blocks, drawing cutting, writing, etc?)
_____

- **MEDICAL/HEALTH HISTORY**

If your child has had any of the following, please describe and give age of occurrence(s):

- Asthma: _____
- Acid Reflux (GERD): _____
- Chronic colds: _____
- Seizures: _____
- Dental problems: _____
- Ear infections: _____
- Encephalitis: _____
- Head injuries: _____
- Meningitis: _____
- Pneumonia: _____
- Tonsilitis: _____
- Tonsillectomy: _____
- Adenoidectomy: _____
- P E Tubes: _____
- Describe any respiratory problems (noisy breathing, etc): _____
- Describe any gastrointestinal problems (vomiting, diarrhea, constipation, gas, colic, etc): _____
  Does your child use a pacifier: _____

If your child has had any of the following diagnoses, please check, describe, and give age of occurrence(s):

- Cerebral Palsy: _____
- Developmental Delay: _____

- Autism: _____
- Cleft Lip/Palate: _____
- Respiratory Difficulties: _____
- Other significant Illnesses: _____
- Tests/X-Rays/Modified Barium Swallow Study/Ultrasound?:
  _____
  _____

Any concerns with your child's hearing? ϒ Y ϒ N

_____

Has hearing been recently checked? ϒ Y (Date: _____) ϒ N

Any concerns with your child's vision? ϒ Y ϒ N

_____

Has vision been recently checked? ϒ Y (Date _____) ϒ N

- **EDUCATIONAL HISTORY**

My child attends:

- Daycare
- Preschool
- Kindergarten
- Elementary School
- Junior High/Middle School
- High School

Is your child currently under an Individual Family Service Plan (IFSP)? ϒ Y ϒ N

Is your child currently under and Individualized Education Plan (IEP) or a 504? ϒ Y ϒ N

Grade: _____ School: _____

How is your child doing in school? _____

Please list and describe any special services your child receives from the Infant Toddler Program (Birth to Three), Daycare/Preschool, or School (behavioral intervention, special education, psychiatric, etc): _____

_____

_____

_____

- **ACTIVITIES OF DAILY LIVING**

Infants:

Where does your child spend the day (e.g. daycare, home, etc):_____

What positioning tools does your infant use (if any)?

- Infant swing
- Bouncer seat

- Johnny jump-up
- Exersaucer
- Boppy pillow
- Bumbo seat
- Car seat/carrier
- High chair
- Other: _____

How much floor time does your infant receive?

On his/her back: _____

On his/her tummy: _____

Where does your child nap/sleep? (crib, bassinette, floor, parent bed, infant swing, carseat, other): _____

Toddlers and up:

Is it easy for your child to fall asleep: ϒ Y ϒ N (Explain: _____)

Is it easy for your child to wake up after sleep? ϒ Y ϒ N (Explain: _____)

Does your child have strong likes or dislikes toward foods or food textures? ϒ Y ϒ N

Likes? _____

Dislikes? _____

Does/did your child demonstrate the following?

Good seal around bottle and/or breast during feeding

Loss of fluid from mouth during feeding

Does your child explore toys or other objects with his/her mouth? _____

*(Answer self-care section only if child is **over** the age of 3 years old)*

HOW MUCH ASSISTANCE DOES YOUR CHILD REQUIRE FOR SELF-CARE (*circle one*):

undressing?	ϒ Independent	ϒ with some help	ϒ needs a lot of help
dressing?	ϒ Independent	ϒ with some help	ϒ needs a lot of help
put shoes and socks on?	ϒ Independent	ϒ with some help	ϒ needs a lot of help
take shoes and socks off?	ϒ Independent	ϒ with some help	ϒ needs a lot of help
need help with fasteners?	ϒ Independent	ϒ with some help	ϒ needs a lot of help
use utensils to feed self?	ϒ Independent	ϒ with some help	ϒ needs a lot of help
drink from a glass?	ϒ Independent	ϒ with some help	ϒ needs a lot of help
drink from a straw?	ϒ Independent	ϒ with some help	ϒ needs a lot of help
use the bathroom?	ϒ Independent	ϒ with some help	ϒ needs a lot of help
stay dry during the night?	ϒ Y ϒ N	Explain: _____	

Does your child undress? ϒ Independent ϒ with some help ϒ needs a lot of help

Any concerns regarding dressing skills (e.g. getting dressed/undressed, managing buttons/snaps/zippers, shoe-tying): _____
Any concerns regarding hygiene skills (e.g. tooth brushing, bathing, combing hair, toileting): _____

- **SENSORY MOTOR SKILLS**

Please check any statements that describe your child:

- Frequently trips on his/her own feet
- Walks on his/her toes
- Frequently bumps into furniture, walls, or other people
- Unaware of being touched or bumped unless done with extreme force
- Unaware that face or hands are dirty (e.g. nose running, food on face)
- Seems unsure of how to move his/her body; is clumsy and awkward
- Slumps or slouches when sitting; places head on hands when sitting
- Has difficulty learning new motor tasks
- Is in constant motion
- Has difficulty sitting still
- Chews on pens, straws, shirts, etc.
- Frequently touches people and objects
- Frequently gets in everyone else's space
- Is overly sensitive to touch, noise, smells, etc.
- Avoids touching certain textures (please list: _____)
- Avoids messy play (e.g. finger paints, playdough, mud, sand)
- Only eats certain foods or food textures (please list: _____)
- Is sensitive to clothing tags or textures
- Complains about having hair brushed
- Resists having teeth brushed
- Does not like to have fingernails trimmed
- Refuses to walk barefoot
- Has trouble falling asleep or staying asleep
- Gets "stuck" on toy or task and has difficulty changing to another task
- Is fearful on swings
- Is fearful of slide or other playground structures
- Is fearless on playground equipment

- **FOOD AND NUTRITION**

Was your child breast-fed? ϒ Y ϒ N
If yes, for how long? _____
Does your child still breast-feed? ϒ Y ϒ N
Did your child ever have any trouble with breast-feeding (e.g. poor suck, slow to feed, poor latch, nipple shield): _____
When was your child's first bottle: _____

Did your child have any trouble with the bottle? _____

- **CURRENT FEEDING INFORMATION**

What is your child's current *weight:* _____ *height:* _____

Where does your child fall on the growth charts:

Percentile weight: _____

Percentile height: _____

Percentile head circumference: _____

How would you describe your child's appetite?

- Good
- Fair
- Poor
- Varies

Which of the following does your child drink?

- Cow's milk
- Soy milk
- Breast mild
- Formula
- Other: _____

If your child is nursing, does mother have adequate production of milk? ϒ Y ϒ N

How much of the following does your child eat and drink in a typical 24-hr period?

Food: _____

Liquid: _____

Supplements: _____

How long does each meal take? _____

What bottle and nipple does your child use to nurse? _____

Does your child use any special equipment to eat?

- Bottle
- Nipple
- Cup
- Spoon
- Other: _____

What is your child's favorite position when eating/being fed?

- Held by caregiver (describe position _____)
- In seating device (describe _____)

Does your child receive any supplemental feeding: ϒ Y ϒ N

If yes, please check:

- NG
- PEG
- PEJ
- Oral supplementation

Any concerns regarding feeding and eating skills (e.g. using spoon/fork, drinking through straw, food choices, ability to chew/swallow): _____
Any concerns about food choices (e.g. selective eater, eats only certain foods or textures):
_____

- **SOCIAL INFORMATION**

  My child (Please check all that apply):
  - gets along with other children
  - prefers to play alone
  - prefers to play ***next to*** other children (minimal to no talking among children)
  - prefers to play with 1 or 2 others
  - plays mostly with siblings
  - prefers to play ***with*** other children (playing and talking jointly)
  - plays mostly with adults
  - has a lot of friends

  Please describe your child's play. What does s/he like to play? Favorite games and toys/interests?

  _____
  _____
  _____

  Is your child easily distracted or does s/he have trouble functioning if there is a lot of noise around? ϒ Y ϒ N
  Explain: _____
  Is s/he afraid of certain things, persons, animals, or situations? ϒ Y ϒ N
  Explain: _____
  How is your child best calmed when upset? _____
  Child's strengths and interests:

  _____
  _____
  _____
  _____

  Reason for seeking evaluation and/or treatment:

  When did you first have concerns about your child? _____
  What made you concerned? _____
  What strategies or techniques have you been trying independently?

  _____

  What is your primary concern today?

  _____

Goals for therapy (What specific skills would you like your child to achieve in therapy?):

- _____
- _____
- _____
- _____

Name of individual completing the above health history:

_____ _____ _____

(please print name) (signature) (date)

Relationship to patient:

- Parent
- Foster parent
- Caseworker
- Legal guardian
- Other: _____

Name: _____ Date: _____

Consistency with therapy plan of care is of the utmost importance in helping your child reach his or her potential. In an effort to provide consistent, high-quality continuity of care, our team will do our best to schedule several appointments at a time, in order to ensure your therapy day/time preference. However, based on variability with insurance policies regarding authorization for services, the occasional appointment ***may need to be cancelled*** as we wait for authorization to be completed. Our team will let you know 24 hours in advance of your scheduled appointment if it needs to be cancelled due to insurance authorization reasons. We thank you for your understanding and will do all we can to ensure a seamless therapy experience.