kitsap physical therapy
AND SPORTS CLINICS

Outpatient Pediatric Health History

I. IDENTIFYING INFORMATION **Today's Date: _____**

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

Age: _____ ☐ Male ☐ Female
Nickname: _____

**** 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: _____
Parent email address (es): _____

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:
_____
Primary Care Physician: _____

Other children in the family:

Name	Sex	Age	Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

If yes, please explain: _____

II. 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 _____

III. 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: _____

IV. 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*

1. _____
2. _____
3. _____
4. _____
5. _____

V. 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: _____

VI. 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

A. 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)? _____

B. 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:
_____
_____

C. 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: _____

VII. 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?)
_____

VIII. 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? □ Y □ N

_____

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

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

_____

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

IX. 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)? □ Y □ N

Is your child currently under and Individualized Education Plan (IEP) or a 504? □ Y □ 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): _____

_____

_____

_____

X. 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: □ Y □ N (Explain: _____)

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

Does your child have strong likes or dislikes toward foods or food textures? □ Y □ 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?	□ Independent	□ with some help	□ needs a lot of help
dressing?	□ Independent	□ with some help	□ needs a lot of help
put shoes and socks on?	□ Independent	□ with some help	□ needs a lot of help
take shoes and socks off?	□ Independent	□ with some help	□ needs a lot of help
need help with fasteners?	□ Independent	□ with some help	□ needs a lot of help
use utensils to feed self?	□ Independent	□ with some help	□ needs a lot of help
drink from a glass?	□ Independent	□ with some help	□ needs a lot of help
drink from a straw?	□ Independent	□ with some help	□ needs a lot of help
use the bathroom?	□ Independent	□ with some help	□ needs a lot of help

stay dry during the night? □ Y □ N Explain: _____

Does your child undress? □ Independent □ with some help □ 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):

_____

XI. 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

XII. FOOD AND NUTRITION

Was your child breast-fed? □ Y □ N

If yes, for how long? _____

Does your child still breast-feed? □ Y □ 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? _____

XIII. 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? □ Y □ 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: □ Y □ 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):

_____

XIV. 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? □ Y □ N
Explain: _____
Is s/he afraid of certain things, persons, animals, or situations? □ Y □ 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?):

1. _____
2. _____
3. _____
4. _____

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: _____