OCONEE
Medical Center

Rehabilitation Services Pediatric Patient Questionnaire

(All information will remain confidential

Patient name: Date of Birth: / / ☐ Male ☐ Female Date: Time:				
At times we may need to contact you by phone. May we leave a telephone message for you? ☐ Yes ☐ No				
Contact person: Relationship to child?				
Home Phone: Cell Phone: Work Phone:				
Current Height: Current Weight: Primary Language: ☐ English ☐ Spanish ☐ Other:				
Primary Care Physician: Referring Physician:				
Please list the names and ages of the people who live in the same home as this child				
Please describe the problem for which your child was referred to therapy.				
Birth History of your child	**Yes**	**No**	**Unknown**	**Explain**
Age of mother at birth: Duration of labor:	Problems during labor or delivery:			
Birth weight				
Full term? (40 weeks)				
Blue at birth?				
Jaundice at birth?				
Respirator problems requiring ventilator?				
Extended hospitalization after birth?				
Problem requiring home apnea monitor?				
Infants only: apnea, bradycardia (slow heart rate)?				
What are your goals of therapy for this child?				
When will you follow up with the physician who referred your child to therapy?				
Please list ALL medications your child currently takes including over the counter and herbal supplements.				
Does your child have any allergies to any:	**Yes**	**No**	**Unknown**	**Reaction**
Medications? (list):				
Foods? (banana, kiwi, avocado, tomato):				
Latex ?(sneakers, balloons, rubber cause itching or wheezing)?				
Please complete the age at which this child achieved the following developmental milestones:				
Roll Sit unsupported Crawl Pull to stand Cruise Walk unassisted				
Potty/Toilet trained Dress self Feed self independently with utensils				
Babble Use Jargon Use single words Combine words				
Please complete the following questions about daily routine:				
Does this child take naps? How long? How many a day?				
Does this child attend school or preschool? What grade? Is "special" education given?				
Does this child have any favorite hobbies or toy? If so what?				
What type of discipline is used at home?				
Does this child have adaptive equipment at home? Stander? Splints or braces? Special Seating?				
Wheelchair? Walker/crutches? Oxygen? Monitor? Other?				

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Health Conditions-*Check all that apply(WNL means 'Within Normal Limits')*

Respiratory ☐WNL	**Cardiac** ☐WNL	**Bleeding Circulation** ☐WNL	**Neurological/Mental Health** ☐WNL
☐ Asthma ☐ BPD (broncho-Pulmonary Dysplasia ☐ Wheezing ☐ Croup ☐ Upper Respiratory Infection. ☐ Shortness of Breath ☐ Sleep Apnea ☐ TB	☐ Heart Murmur ☐ Congenital Heart defect ☐ Irregular heart beat	☐ Anemia ☐ Bleeding disorder ☐ Easy bruising ☐ Excessive Bleeding ☐ Sickle Cell Anemia ☐ Transfusion of Blood/plasma	☐ Seizures ☐ Depression / Anxiety ☐ ADHD ☐ Emotional Problems ☐ Learning Disabilities ☐ Prenatal drug exposure
Endocrine ☐WNL ☐ Diabetes. Controlled by: Circle: *Diet / Pill / Insulin* ☐ Hepatitis ☐Thyroid Problems ☐ Adrenal disease ☐ Other:	**Musculoskeletal** ☐WNL ☐ Juvenile Rheumatoid Arthritis ☐ Muscle weakness ☐ Torticollis ☐ Plagiocephaly ☐ Joint Contracture ☐ Spasticity ☐ Abnormal movement	**Gastrointestinal** ☐WNL ☐ Difficulty swallowing ☐ Hernia ☐ Reflux ☐ Feeding tube	**Infectious Diseases** ☐WNL ☐ Recent Mono ☐ HIV ☐ Hepatitis A, B, C ☐ MRSA location:_______ ☐ VRE ☐ C. diff ☐ RSV ☐ Ear infections
Hearing & Vision ☐WNL ☐ Hearing loss ☐ Hearing Aide ☐ "Lazy eye" ☐ "Cross eyed" ☐ Glasses ☐ Contacts ☐ When last tested:	**Skin** ☐WNL ☐ Rashes ☐ Sore/Open areas ☐ Hemangiomas ☐ Birthmarks		**Other** ☐WNL ☐ Developmental Delays ☐ Immunizations up to date

Has your child been hospitalized for any of the above conditions or other conditions? Explain:

Surgical History: (Check all that apply)

☐ **No Prior Surgery** ☐ Appendectomy ☐ Circumcision	☐ Ear tubes ☐ Heart Surgery ☐ Hernia	☐ Hypospadius ☐ Pyloric stenosis ☐ Tonsils and Adenoids	**List any others:**

Please write any additional comments here.

If filled out by Patient: *Patient Signature*:	Date:	Time:
If filled out by Patient Representative: *Signature*:	Date:	Time:
Representative's Relationship to Patient:		

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