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Pediatric Physical Medicine & Rehabilitation New Patient Intake Form

Today's Date: _____ Patient MRN: _____

Patient Name: _____ Date of Birth: _____ Sex: Male / Female

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail Address: _____

Emergency Contact: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail Address: _____

Referring Physician: _____ Phone Number: _____

Address: _____

Primary Care Physician: _____ Phone Number: _____

Address: _____

Please check all that apply

- ☐ No Allergies
- ☐ Drug Allergy Medication name: _____ Reaction: _____
- ☐ Food Allergy Food: _____ Reaction: _____
- ☐ Latex Allergy
- ☐ IV Contrast Allergy
- ☐ Other: _____

Immunizations up-to-date

- ☐ Yes
- ☐ No

Date of last Influenza Vaccination: _____

Please list all medications/herbals/vitamins/supplements:

DRUG	DOSE	ROUTE	FREQUENCY

Therapies:

- ☐ Physical Therapy
  - o If yes, how often? _____
- ☐ Occupational Therapy
  - o If yes, how often? _____
- ☐ Speech Therapy
  - o If yes, how often? _____
- ☐ Aqua Therapy
  - o If yes, how often? _____
- ☐ Other
  - o How often? _____

Do you use any of the following? Check all that apply.

☐ Braces ☐ Splints ☐ Stander ☐ Walker ☐ Wheelchair

Please describe: _____

_____

_____

Birth History:
Duration of Pregnancy: _____ weeks. Vaginal Birth Yes / No Caesarian Birth Yes / No

Premature Delivery: Yes / No If yes, Why? _____ Birth weight: _____

Complications during pregnancy: _____

Time spent in the Neonatal Intensive Care Unit (NICU): _____

Was you child ever on a mechanical ventilator: Yes / No If yes, how long? _____

Development History:
If developmental milestones were NORMAL please check here: ☐

At what age did your child begin to sit when placed? _____

At what age did your child begin to sit independently? _____

At what age did your child begin to roll over? _____

At what age did your child begin to crawl? _____

At what age did your child begin to pull to stand? _____

At what age did your child begin to walk? _____

At what age did your child begin to talk? _____

Family History:
Please list any medical problems that run in your family.

Relationship	Medical Problem	Relationship	Medical Problem
Mother:		Maternal Grandfather:	
Father:		Maternal Grandmother:	
Sibling(s):		Paternal Grandfather:	
Other:		Paternal Grandmother:	

Social History:
Who does your child live with? _____

Do you live in a: House? Yes / No Apartment? Yes / No How many steps in the home? _____

What school, daycare, or IEP does your child attend? _____

Does your child participate in any physical activities? Yes / No If yes, what kind? _____

Adolescent patients only:

Smoking History: Yes / No Alcohol History: Yes / No Sexually Active: Yes / No

Drug History: Yes / No Date of 1st menses (females only): _____

Review of Systems: Current History
Please circle all that apply:

Fevers/chills/unintentional weight change/chronic pain/infections?	YES/ NO
Difficulty seeing/hearing/double vision?	YES/ NO
Difficulty swallowing/headaches/seizures/falls/drooling/choking?	YES/ NO
Chest pain/palpitations/fainting/sweating?	YES/ NO
Shortness of breath/wheezing/cough/snoring?	YES/ NO
Nausea/vomiting/diarrhea/reflux/loss of control of stools/constipation?	YES/ NO
Loss of control of urine/urinary frequency/urgency/retention?	YES/ NO
Dizziness/weakness/numbness/tingling?	YES/ NO
Depressed mood/sleep problems/anxiety/agitation/mood swings?	YES/ NO
Pain/spasticity/dystonia/scoliosis/abnormal gait/joint swelling?	YES/ NO
Rash/sores/eczema/itching/ecchymosis/non healing wounds?	YES/NO
Cancer/sickle cell/anemia/bleeding disorder?	YES/NO
Diabetes/thyroid disease/lupus/excessive fatigue?	YES/NO

Past Medical/Surgical History. Please circle Yes or No:

Developmental delay	Yes	No	Seizure disorder	Yes	No	Head injury	Yes	No
Hydrocephalus	Yes	No	Ventriculoperitoneal shunt	Yes	No	Glasses or contacts	Yes	No
Nystagmus	Yes	No	Strabismus	Yes	No	Retinopathy of prematurity	Yes	No
Problems with speech	Yes	No	Hearing Aides	Yes	No	Ear tubes	Yes	No
Frequent ear infections	Yes	No	Nose bleeds	Yes	No	Sinus infections	Yes	No
Frequent strep infections	Yes	No	Bleeding gums	Yes	No	Tracheostomy	Yes	No
Tonsillectomy	Yes	No	Adenoidectomy	Yes	No	Dental procedures	Yes	No
Aspiration pneumonia	Yes	No	Chronic lung disease	Yes	No	Frequent suctioning	Yes	No
Viral or Bacterial pneumonia	Yes	No	Asthma	Yes	No	Heart murmur	Yes	No
Patent Ductus Arteriosus	Yes	No	Cardiac Surgery	Yes	No	Congenital heart defect	Yes	No
Gastroesophageal Reflux	Yes	No	G-tube placement	Yes	No	J-tube placement	Yes	No
Special diet	Yes	No	Nissen Fundoplication	Yes	No	Liver disease	Yes	No
Urinary tract infections	Yes	No	Kidney disease	Yes	No	Trauma	Yes	No

Contractures	Yes	No	Hip subluxation or dislocation	Yes	No	Hip osteotomy	Yes	No
Soft tissue surgery	Yes	No	Rhizotomy	Yes	No	Spinal fusion	Yes	No

Date of last hip x-ray? _____

Date of last MRI? _____

Date of last swallow study? _____

Date of recent blood work? _____

Please list all other medical problems, surgeries, recent illnesses and injuries below:

_____

_____

_____

_____

_____

_____

_____

_____

Completed by: _____

Date: _____

Reviewed by: _____

Date: _____