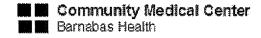
THIS SURVEY WILL HELP US TO ESTABLISH AN APPROPRIATE EVALUATION AND TREATMENT PROGRAM FOR YOUR CHILD. ANY INFORMATION WILL BE CONSIDERED WITH THE STRICTEST CONFIDENCE AND WILL BE PART OF YOUR MEDICAL RECORD.

Allergies: List any medication or foods your child is allergic to:
Does your child have a latex sensitivity? YES NO List any other allergies we should know about:
Please check any of the following whose care your child is under: Pediatrician Allergist Occupational Therapist Ear Nose Throat Doctor Psychiatrist Speech Therapist Neurologist Physical Therapist Early Intervention Other
If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.)
Has your child ever been diagnosed with any medical conditions? If so please list:
Has your child ever had a hospitalization or surgery? If so please list and explain:
Is your child currently taking any prescription or over the counter medications? If so please list:
Has your child had their hearing checked? YES NO Therapists Notes:





Patient Label

Were there any difficulties during pregnancy and del If so list:	ivery? YES NO
Was the child premature? YES NO If so at what week gestation was he/she born? _	
Has your child achieved the following developmenta possible.	I milestones? Please indicate approximate age if
sitting up say rolling over say crawling pot walking self	s 2 word combination by trained
Why did you bring your child today for the evaluation	? What are your major concerns?
What are your goals for therapy?	
Are there any issues/concerns that you have about y	our child that you would like us to be aware of?
Therapists Notes:	
Therapist Signature: Date/Time of Evaluation:	
Date/ Tillie of Evaluation.	
Community Medical Center Barnabas Health	Patient Label

PEDIATRIC MEDICAL HISTORY

THIS SURVEY WILL HELP US TO ESTABLISH AN APPROPRIATE EVALUATION AND TREATMENT PROGRAM FOR YOU. ANY INFORMATION WILL BE CONSIDERED WITH THE STRICTEST CONFIDENCE AND WILL BE PART OF YOUR MEDICAL RECORD.

Name):		0	ccupa	ion:		
ALLE	RGIES:	List any medication(s) you are allergic to: Are you latex sensitive? YES NO List any other allergies we should know about: Do you have an advanced medical directive? YES NO (If yes, please bring in a copy for your record)		*			`
Pleas	e check	✓) any of the following whose care you are under:					
	Medical [Doctor (MD)Psychiatrist/Psychologist	Other	•			
(Osteopat	hPhysical Therapist					
	Dentist	Chiropractor					
If you	have see	en any of the above during the past three months, please describ	e for wh	at rea	son (illnes	s, medi	ical condition, physical, etc)
Have	you ever	been diagnosed as having any of the following conditions?					
YES	NO	Cancer. If YES, describe what kind			YES	NO	Rheumatoid arthritis
YES	NO	Heart Problems		-	YES	NO	Arthritis
YES	NO	Heart Attack/Angina			YES	NO	Total Joint Replacement
YES	NO	Pacemaker			YES	NO	Osteoporosis
YES	NO	High blood pressure			YES	NO	Depression
YES	NO	Circulation problems			YES	NO	Hepatitis
YES	NO	Asthma			YES	NO	Tuberculosis
YES	NO	Emphysema/Bronchitis/COPD			YES	NO	Stroke
YES	NO	Chemical Dependency (alcohol/drugs)			YES	NO	Kidney Disease
YES	NO	Thyroid Problems			YES	NO	Liver Disease
YES	NO	Diabetes			YES	NO	Anemia
YES	NO	Multiple Sclerosis			YES	NO	Epilepsy
YES	NO	Dialysis			YES	NO	Metal Implants
YES	NO	Dizziness			YES	NO	Amputations
YES	NO	Prostate problems			YES	NO	Other
YES	NO	Loss of Sensation					·
Ther	apist's N	otes:					
Have	you had	any diagnostic tests for this problem? (x-ray, MRI, etc)					
Do yo	ou ever fe	el unsafe at home or has anyone tried to injure you in any way?	YES	NO			
FOR	WOMEN	: Are you currently pregnant or think you might be pregnant?	YES	NO			
Do yo	ou smoke	? YES NO How much per day?					
•		ng you post-surgery, may we access your surgical record?	YES	NO		~~	
	ou require	e assistance with normal activities? YES NO 6, who provides this assistance?					
Have		any falls within the past year? YES NO If yes, how many?_			Were you	injured	YES NO

Community Medical Center

RWJBarnabasHealth



Patient Label

Please describe any significant injuries for which you have been treated fractures, sprains, dislocations and the approximate date of the injury.

Patient Label

Please list any surgeries, conditions for which you have been hospitalized, including the approximate date and reason:

atient's Signature			- Date	əmiT		
enutangi2 s'taiqaneh			Printed Name		Date	əmiT
herapist's Motes;						
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7						
y gosls in therapy are:						
ly current pain level is:		ld describe ma				
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nmpuese ot fingling	XES	ON				
ever/chills/sweats	XES	ON				
уеаклеss	KES	ON				
əugita	XES	ON				
gnijimov\sesus	XES	ON				
/eight loss/gain	XES	ON				
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lease list any PRESCRIPTION	edication	Non ste currentl	y taking (INCLUDING	3 pills, injections, and/or sl	skin patches)	
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biostn	人ES	ON				
aənimstairlitn	XE2	ON				
econgestants	XES	ON				
səvilexe	XES	ON				
dvil/Motrin/Ibuprofen	XES	ON		i		
oue	KES	ON				
nhiqa	ΛES	ON				
/hich of the following OVER-TH	COUNTE	R medications h	sve you taken in the	s last week?		
		W 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4				

CMC 2199

Community Medical Center

REHAB MEDICAL HISTORY FORM

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