Saint Barnabas Medical Center | RWJBarnabas HEALTH

Pediatric Occupational & Physical Therapy
(973) 969-3434
(973) 969-3632 (fax)

CHILD MEDICAL HISTORY FORM Date: _____

Thank you for scheduling your child's evaluation at St. Barnabas Medical Center, Pediatric Rehabilitation Department. Please take a few minutes to **fill out this form as completely as possible.**

Child's Name: _____ Gender: Male/ Female DOB:_____ Age: _____
Parent/Caregiver Name/ Occupation: _____Parent/Caregiver Name/ Occupation: _____
Phone: (Home) _____ Phone (Cell)_____ Email Address: _____
Language spoken at home:_____ Siblings (Ages/ Genders)_____
Referring MD/ Phone Number: _____
Primary MD or Pediatrician/ Phone Number: _____
Immunizations up to date: Yes ____ No_____ If no; Reason_____

Medications: _____ ☐ **None**
List any allergies to food or medication: _____ ☐ **None**
Medical or Behavioral Problems:_____ ☐ **None**

What is the reason your child is here: What are your current concerns?_____
_____
What are you goals and expectations for your child:_____
_____

Birth History: Pregnancy- How many weeks? _____ Singleton ☐ Twin A ☐ Twin B ☐
Mother's Health/ Conditions/ Drug Use/ Medications: _____
_____

Delivery: Natural ☐ Cesarean ☐ Labor Induced ☐ Duration of Labor:_____
Complications (baby's position, forceps, suction):_____
Post-natal: Birth Weight_____ Height_____ APGAR scores: 1 min_____5 min____
Jaundice ☐ Light therapy ☐ (Duration) _____ NICU length of stay_____
Feeding Tube_____ Respiratory Issues/ Details_____
Other:_____
Length of Time: Breast Fed: _____ Formula Fed:_____ Pacifier ☐ Thumb sucked ☐

Medical/Surgical History: List significant past or current medical conditions of child (i.e. **illnesses, hospitalizations, surgeries, genetic conditions**_____ ☐ **None**

Illness/ Condition	**Frequency**	**Treatment/ Hospitalization/ Date**
Ear Infections/ Tubes		
Tonsils/ Adenoids		
Seizures		
Allergies		
Asthma		
Fevers/ Colds		
Heart Disease		
Measles, Mumps, Diptheria, Pertussis		
Constipation		
GERD		

Current Concern or History of Torticollis (Wry Neck)/ Plagiocephaly (Flat Head): Yes ☐ No ☐

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When was your child's last hearing checkup? _____

a. What issues were discovered? _____

b. Does your child require a hearing device? Yes ☐ No ☐

When was your child's last vision checkup?_____

c. What issues were discovered? _____

d. Does your child require glasses? Yes ☐ No ☐

Did your child achieve developmental milestones on time? Yes ☐ No ☐

Milestone	Age Achieved	Not yet achieved	Comments
Rolling belly to/ from back			
Sitting alone			
Crawling on hands & knees			
Standing Alone			
Walking Alone			
Finger Feeding			
Chewing Solids			
Scribbling			
Babbling			
Toilet Trained			☐ Dry Day ☐ Dry Night

Did your child require early intervention services? Yes ☐ No ☐

Where does your child attend school/grade? (Indicate private, public, inclusion, self-contained):_____

_____

List other care your child receives/ received: (include in-school, out-patient, in-home):

Check if applicable, **List Names and Frequency**:

☐Physical Therapist ☐ENT ☐Physiatrist

☐Occupational Therapist ☐Audiologist ☐Cardiologist

☐Speech Therapist ☐Neurologist ☐Psychologist

☐Child Study Team ☐Orthopedist ☐Social Worker

☐Behavioral Therapist ☐Developmental Pediatrician

_____

_____

_____

List any other significant issues that may help us understand your child better (medical, social, behavior, fears, phobias, academic difficulties, issues with transitions, etc.) _____

_____

Anything else you would like us to know: _____

Barriers to Learning: ☐Blind ☐Deaf ☐Cognitively Impaired ☐Language ☐Emotional/Anxiety

☐Other(specify): _____