PEDIATRIC HEALTH HISTORY

Please help us to understand how to best meet your child's needs by completing this health information. We look forward to working with your child!

Date: _____Grade: _____Age: _____ DOB: _____

Child's Name: _____ Parent/Guardian Name: _____

Address: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Siblings: _____School: _____

MEDICAL HISTORY

Diagnosis: _____

What are your main concerns for your child? _____

Other health Issues: _____

_____

Does your child have the following?

Hearing loss _____Visual impairment _____G Tube _____NG Tube_____

Incontinence _____ Skin breakdown _____Ear tubes _____ Swallowing issues _____

Please indicate procedures, surgeries and/or hospitalizations below.

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

Medications: _____

Allergies/latex sensitivity: _____

Has your child ever had a seizure? If yes, please explain. _____

_____

Has your child ever had any head injuries? If yes, please explain. _____

_____

BIRTH HISTORY

Is your child adopted? _____
Vaginal delivery ____ Cesarean section ____ Full term ____ Preterm _____ Birth weight _____

Special equipment needs at home and/or school: _____

SCHOOL

Is your child currently on an IEP? _____Date? _____ If yes, please provide a copy.

What areas were evaluated? _____

Has your child had a psychological evaluation? If so, please describe. _____

_____

Does your child currently receive any special services? If yes, please describe below.

Early Intervention _____

Physical Therapy _____

Occupational Therapy _____

Speech Therapy _____

Other services/interventions? Please describe:

_____

_____

Do you have concerns about your child's school situation and services? _____

_____

ACTIVITIES OF DAILING LIVING, PHYCHO-SOCIAL AND RECREATIONAL

Does your child have any difficulties with any of the following? If yes, please explain.

____Attention span
____Sensitive to sound
____Physical aggression
____Self image
____Understanding (receptive language)
____Anxiety
____Sensory Issues
____Expressing self and making needs known
____Making transitions from one activity to another
____Toileting
____Dressing
____Forming relationships
____Trouble following directions
____Temper tantrums

_____

_____

Previous swimming experience: _____

What types of activities does your child enjoy? _____

What are your child's favorite things? _____

What are your child's strengths? _____

Is there anything else you would like us to know about your child that would assist us in meeting your child's needs? _____

_____

_____