Vanderbilt Rehabilitation Center of Newport Hospital
A Lifespan Affiliate

Name: _____

Unit Record #: _____

OUTPATIENT PEDIATRIC HISTORY INTAKE

In order for Vanderbilt Rehabilitation Outpatient Center to best treat your child and comply with hospital regulations, please complete this form to the best of your ability.

What brings your child to therapy? _____ When did this begin? _____

What is the history of this concern? _____

BIRTH HISTORY: Were there any problems during pregnancy or delivery? ☐yes ☐no

If yes, please describe: _____

List the approximate age at which your child was able to	***SKILL***	***AGE***	***SKILL***	***AGE***
GROSS MOTOR	Sit unsupported		Walk	
FINE MOTOR	Be weaned from a bottle		Drink from a sip cup	
	Feed self		Dress independently	
SPEECH	Babble		Speak first words	
	Put two words together		Follow simple directions	

Social/Educational History:

Who lives at home with your child: _____

Daycare? ☐yes ☐no School? ☐yes ☐no Name of school: _____ Grade: _____

What language(s) is spoken at home? _____ Do you need an interpreter? ☐yes ☐no

What are your child's interests? _____

What are your child's favorite activities? _____

Prescription medications			
List all the brand-name and generic prescription medications you currently take.			
Name *(Please print)*	**Reason for taking medication**	**Dosage**	**Frequency (daily, weekly)**

Please list any hospital stays or NICU stays (include approximate age): _____

_____

_____

Please list any surgeries (include approximate age):_____

_____

Current health concerns: _____

Past health concerns: _____

Please list allergies (ex: medication, latex, environmental): _____

Precautions or any special medical needs/considerations: _____

_____

Special tests or screenings (x-ray, MRI, developmental tests, video swallow). If so, please include the approximate date and result: _____

_____

Do you have any concerns about height, weight, or head circumference? □yes □no

Is your child experiencing pain? □yes □no If yes, is it relating to reason for referral? □yes □no

Does your child have a history of the following?							
CONDITION	**NO**	**YES**	**COMMENTS**	**CONDITION**	**NO**	**YES**	**COMMENTS**
Seizures				Heart problems			
Cancer				Brain injury			
Diabetes				Neck/back injury			
Fracture				Juvenile RA			
Ear infections				Bowel/bladder problems			
Asthma				ADHD/ADD			
Physical abuse				Sexual abuse			
Behavioral problems				Emotional problems			
Hearing problems				Visual problems			
Speech problems				Learning disability			
Ear infections							
Does your child?							
Wear a hearing aid				Wear glasses			
Wear a splint or trunk/leg brace				Have a G-tube			
Have PE tubes				Have trouble feeding or swallowing?			

Treatment History:

Is your child receiving therapy at school? □yes □no If so, please list: _____

Besides a pediatrician, are there any other physicians or therapists who treat your child? _____

_____

Is there any specialized equipment you use at home or your child uses at school? _____

_____

Do you have any equipment needs? □yes □no

My expectation is that therapy will enable my child to: _____

_____

To be completed following the evaluation

I give permission for my child to participate in treatment and understand that during such treatment, whether it e on or off hospital grounds, it is expected that I (or an appropriate caregiver I choose) remain with my child. Please note: if your child has a fever or is absent from school on the day of therapy due to illness, refrain from attending therapy.

____ I have reviewed the above information. _____ I witness the client or authorized representative signature.

_____ _____ _____

Parent Signature/Authorized Representative Date Time

_____ _____ _____

Therapist Signature Date Time