SAINT PETER'S UNIVERSITY HOSPITAL

PHYSICAL MEDICINE AND REHABILITATION DEPARTMENT
PEDIATRIC INTAKE FORM

Name of Child (Printed): _____Name of Parent/Guardian filling out form (Printed): _____
Relationship to Child: _____ Date: _____

Please check or circle all approrpiate boxes for your child. All information will be kept strictly confidential..

Pertinent Medical History	Yes	No	Comments
Does your child have:			
1. Congenital heart defects			
2. Seizures			
3. IVH (intraventricular hemorrhage)			
4. PVL (Periventricular leukomalacia)			
5. Hydrocephalus			
6. Cerebral Palsy			
7. Congenital anomalies			
8. Meningitis			
9. BPD (bronchopulmonary displasia)			
10. Neurologic deficits			
11. Tracheostomy			
12. ROP (retinopathy of prematurity)			
13. Craniofacial disorder			
14. Feeding problems			
15. Neural tuve defects			
16. Down Syndrome			
17. Asthma / other			
18. Cancer / blood disorders / anemia			
19. Diabetes			
20. Rheumatoid arthritis			
21. Prematurity			
22. Developmental delay			
23. Other:			

List any specialists your child has seen:

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

Current Health	Yes	No	Comments
Have you noticed any of the following symptoms in your child or does your child compain of:			
1. Weakness in arms Weakness in legs			
2. Recent weight change			
3. Tiredness / sleeping difficulty / apnea			
4. Nausea / vomiting			
5. Bowel / urinary problems			
6. Joint/bone pain/swelling			
7. Fever / chills / sweats			
8. Coordination/balance problems			
9. Dizziness/light-headed/headaches			
10. Night pain			
11. Shortness of breath, cough, difficulty swallowing			
12. Vision problems			
13. Ringing in ears/hearing problems			
14. Difficulty walking			
15. Chest pain/heart palpitations			
16. Skin problems			
17. Depression			
18. Other			
SOCIAL HISTORY	**Yes**	**No**	**Comments**
1. Does your child have any allergies?			
2. Does your child have latex allergy?			
3. Does your child attend day care / preschool / school? If yes, where and how often?: _____			
4. Does your child interact / play with children of same age?			
5. Does your child exercise regularly?			
6. In your child's life, has there ever been DYFS involvement?			
7. Is your child involved with EIP?			
8. Is your child receiving treatment elsewhere?			

Please turno ver and complete the other side

List any prescription medications your child is currently taking (pills, injections, skin patches, inhalers):

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

List any surgeries or recent hospitalizations your child has had and include the approximate date:

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

Does your child take any of the following over the counter medications?

	Yes	No	Comment
Tylenol			
Advil / Motrin / Ibuprofen			
Laxatives			
Decongestants			
Antacids			
Antihistamines			
Vitamins			
Tagamet / Pepcid AC / Zantac			
Other: _____ _____			
Does your child use alternative medicines or herbal supplements?			
Is your child allergic to any medications?			
Does your child use recreational drugs?			

List any broken bones, sprains, dislocations and include the approximate date:

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

Previous injuries, disorders or conditions for which your child received therapy and include approximate date:

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

TESTS	Yes	No	Area of Body
1. X-ray	❑	❑	_____
2. MRI	❑	❑	_____
3. Ultrasound / Bone Scan	❑	❑	_____
4. CT Scan	❑	❑	_____
5. EMG / NCV	❑	❑	_____
6. Other: _____	❑	❑	_____

Has your child been in a car accident or other accident? ❑Yes ❑No _____
_____

Is there anything that would interfere with your child participating in therapy? ❑Yes ❑No _____
_____

Do you or your child have a need to discuss any emotional or physical harm that you or child may be experiencing? ❑Yes ❑No
_____

Do you ever feel unsafe at home or has anyone hit your child or tried to injure your child? ❑Yes ❑No _____
_____

During the past month, has your child felt down, depressed, or hopeless? ❑Yes ❑No_____
_____

During the past month, has your child been bothered by having little interest or pleasure in doing things? ❑Yes ❑No_____
_____

Describe the problem(s) for which you seek rehab services for your child? _____
What happened?_____
How did the problem begin? _____
When did the problem begin? _____
What makes the problem better? _____
What makes the problem worse? _____
When is your follow-up appointment with the doctor? _____