JUPITER MEDICAL CENTER

Jupiter Medical Center
Pediatric Rehabilitation Services

PEDIATRIC THERAPY/TORTICOLLIS CASE HISTORY

The information requested below will help us better understand your child and to develop an effective treatment plan. Please complete as much as you can. Thank you.

Child's Name: _____ Date of Birth: _____ Sex: _____

Child resides at: _____

Telephone (H) _____ (W) _____ Age: _____

Person completing form: _____ Relationship: _____

Address: _____ Phone: _____

Referred by: _____ Physician: _____

Previous testing by: _____ When? _____

Name of Child's Primary Physician: _____ Preferred Hospital: _____

(*Please forward results to this office*)

Please explain what brings you to this center today:

_____

_____

Family History

List all those living in the home:

Name: Age: Relationship:

_____

_____

_____

_____

Languages spoken in the home? _____

Birth History *(Check all that apply).*

This is our: ❑ biological ❑ foster ❑ adopted child.

Age of mother at pregnancy _____. Maternal Factors: ❑First pregnancy ❑Abnormal uterus/pelvis

Any of the following during pregnancy?

❑ German measles ❑ toxemia ❑ accidents, injuries ❑ kidney infection ❑ anemia

❑ unusual position in utero

Please describe, including medical attention: _____

Pregnancy was ❑ full term ❑ premature Number of months: _____

Delivery was ❑ normal ❑ caesarean ❑ breech ❑ forceps ❑ single birth ❑ multiple birth

Length of hard labor: _____ Medication: _____ ❑ Epidural ❑ Spinal

Any additional comments/information:

_____

_____

Birth weight: _____ Length: _____ Any birth injuries? ❑ No ❑ Yes (describe)_____

Was your child: ❑ RH baby ❑ jaundiced ❑ required oxygen

Any special medications or treatment at birth? _____

Is your child: ❑ bottle fed ❑ breast fed; how long? _____

Any feeding problems? ❑ No ❑ Yes; describe: _____

Head shape at birth: ❑symmetric ❑asymmetric ❑wide ❑long ❑other

Medical History: **Are immunizations current? ____** **Child's Wt. _____ Ht. _____**

Illnesses: _____

Hospitalizations: _____

Medications: _____

Precautions: _____

❑ Reflux ❑ Constipation

If child has history of ear infections, please indicate age of first infection _____. How often? _____

Last infection? _____. Treatments _____

Is child being seen by an ear, nose and throat physician? ❑ No ❑ Yes

Has child's hearing been tested? ❑ No ❑ Yes; when? _____ By whom? _____

Results: _____

Vision Problems? _____

Seen by Ophthalmologist? _____

History of Presenting Problem:

Does your baby have any neck tightness? ❑No ❑Yes At what age was it noticed? _____

Does your baby's head tilt to one side at rest or while sleeping? ❑No ❑Yes Which side? _____

Does your baby keep his head turned to one side more than the other? Which side? _____

Has repositioning been attempted? ❑No ❑Yes At what age was it started? _____

Duration of repositioning? _____ Still repositioning? ❑No ❑Yes

Have you been told your baby's head is abnormally shaped? _____

❑ X-Ray ❑Ultrasound ❑Cervical ❑Hip ❑Spine ❑Other

_____

_____

_____

_____

_____

Parent/Guardian Signature: _____ **Date:** _____