Jupiter Medical Center
Jupiter, FL. 33458

PEDIATRIC REHABILITATION SERVICES
THERAPY 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:	Speech/hearing problem:

Languages spoken in the home? _____

Birth History *(Check all that apply).*

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

Age of mother at pregnancy _____

Any of the following during pregnancy?

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

Please describe, including medical attention: _____

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

Delivery was ☐ normal ☐ caesarea ☐ breech ☐ forceps

Length of hard labor: _____ Medication: _____

Any additional comments/information:

_____

_____

_____

Jupiter Medical Center
Jupiter, FL. 33458

PEDIATRIC REHABILITATION SERVICES
THERAPY CASE HISTORY

Child's Name:_____

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

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

Any special medications or treatment at birth? _____

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

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

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

Does the child have a history of *(if yes, please indicate age and check level of severity)*

	No	Yes	Age	Mild	Moderate	Severe
Allergies						
Asthma						
Chicken Pox						
Dental Problems						
Ear Infections*						
Encephalitis						
Head Injury						
High Fevers						
Measles						
Meningitis						
Mouth Breather						
Tonsillitis						
Upper Respiratory Infections						

* 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: _____

Describe any other illness accidents or injuries or hospitalizations, including age and length of stay:

_____

_____

Is child currently under medical treatment or taking any medication? ❑ No ❑ Yes - Please describe:

_____

_____

_____

PEDIATRIC REHABILITATION SERVICES
THERAPY CASE HISTORY

Child's Name: _____

Developmental History

Sat alone at _____ months. Fed self at _____ months. Walked alone at _____ months.

Toilet trained: ❑ day ❑ night ❑ both

Physical development has been: ❑ rapid ❑ normal ❑ slow

Coordination is: ❑ good ❑ clumsy

Feeding difficulty ❑ none ❑ yes; describe: _____

Speech and Language

As an infant, child was responsive (laughed, smiled appropriately) ❑ Yes ❑ No

Age of first sounds _____ Example _____

first words _____ Example _____

phrases _____ Example _____

sentences _____ Example _____

Age at which you were first concerned about speech? _____

What caused your concern? _____

_____

Describe how your child communicates at the present time: _____

_____

Child can be understood by ❑ mother ❑ father ❑ other children ❑ relatives ❑ strangers

Is the child aware of his speech difficulty? ❑ Yes ❑ No ❑ N/A

How does he react? _____

_____

Is the child having difficulty in any other area at this time? _____

_____

SENSORY:

Does your child object to being touched or cuddled?	❑ Yes ❑ No
Does your child isolate self from other children?	❑ Yes ❑ No
Does your child seem overly sensitive to sound?	❑ Yes ❑ No
Does your child have difficulty following moving objects with his eyes?	❑ Yes ❑ No
Does your child appear sensitive to light?	❑ Yes ❑ No
Does your child explore by tasting?	❑ Yes ❑ No
Does your child dislike foods of a certain texture?	❑ Yes ❑ No
Does your child seem fearful in space (e.g., going up & down stairs, teeter-totter)	❑ Yes ❑ No
Does your child often bump into things/fall down?	❑ Yes ❑ No
Does your child prefer fast moving spinning rides?	❑ Yes ❑ No
Does your child seem weaker/stronger than normal?	❑ Yes ❑ No
Does your child manipulate small objects easily?	❑ Yes ❑ No

Jupiter Medical Center
Jupiter, FL. 33458

PEDIATRIC REHABILITATION SERVICES
THERAPY CASE HISTORY

Child's Name: _____

Daily Behavior

How does your child get along with other children? _____

Does your child prefer to play alone? _____

Describe favorite toys and how your child likes to play? _____

_____

_____

Would this child separate easily for therapy? _____

_____

Any other comments: _____

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____