# *Rehabilitation Associates, Inc.* Pediatric Medical Database

**Date:** _____ **Name:** _____ **Date of birth:** _____
**Parent Name:** _____ **Referred by:** _____

**Chosen Name (if different from legal name)/Nickname:**

_____

**Legal Sex:** _____ While we recognize a number of sexes/genders, unfortunately, many insurance companies and legal entities do not. Please understand that the legal name and sex listed on your insurance must be used on documents pertaining to insurance and billing. If your name used and/or pronouns are different from these, please let us know.
**Pronouns (if comfortable sharing):** _____

**Reason for seeking therapy (include for OT, PT & Speech):**

_____

_____
**What are your family's goals for therapy?** _____

_____

**Prenatal/Early Development:**
Difficulties during pregnancy/labor/delivery? ___ Born Premature? ____ Birth Weight: _____
*If yes to above please explain*: _____

**Age at which the following developmental milestones were achieved:**
Rolling: ____ Sitting: _____ Crawling: ____ Walking: _____ Babbling: ___ First Word: _____

**Does your child have a history of:**
Allergies (seasonal, medications, food, etc): __ Frequent ear infections or ear tubes: ___
Seizures: ___ Surgeries or medical procedures: ___ Hospitalizations: ____
Broken bones or dislocations: ____ Visual problems or glasses: ____
Difficulties with hearing: ___ Hearing tested? Yes __ No ___ Date (if yes): ____
Gastrointestinal problems: ___ Cardiac/Heart Problems: ___ Breathing/Lung Problems: ___
Other: _____
**If answered yes to any of above please explain:** _____
_____

_____

**Additional information:**
Does your child use any equipment (orthotics, braces, wheelchair, walker, communication device)? _____
Has your child seen a specialist or had medical/diagnostic testing (x-ray/scan, vision, GI, cardiac, pulmonary, etc)? _____ Is your child up to date with vaccines? yes ___ No(explain below) ___
**If answered yes to any of above please explain:** _____
_____

**Is your child currently receiving or has received any of these services:**

Birth to Three: ____ School Based Therapy: ____ Private/Outpatient Therapy: _____

**If yes please explain:** _____

**Languages spoken at home:** _____

**People who live with your child:** _____

**Describe your child's daycare, educational, and/or play settings:** _____

_____

**What are your child's favorite toys or activities?** _____

**Does your child have any behavioral challenges? If yes, please explain/provide strategies you have found effective:** _____

**Medications:** ___ see attached list ___ none

**Emergency Contact Information (*other than person accompanying this child to therapy*):**

Name: _____ Relationship: _____ Phone: _____

*To be completed by clinician – do not write below this line.*

_____

__ Medical Database reviewed with family.

__ Attendance Policy/cancellation charge reviewed with family.

__ Standing appointments reviewed with family. __ Standing appointments not applicable

_____ _____

*Therapist's Signature* *Date*