Rehabilitation Associates, Inc. Pediatric Medical Database

Date: _____ Patient Name: _____ DOB:_____ Referring Doctor: _____

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):** _____

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

Name: _____ Relationship: _____ Phone: _____

Reason for seeking therapy / What are your family's goals for therapy?

_____

_____

_____

Prenatal/Early Development:

Difficulties during pregnancy/labor/delivery? ___ Born Premature? ____ Birth Weight: _____

If any above are checked 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): __

Seizures: ___

Hospitalizations: ___

Surgeries or medical procedures: ___

Broken bones or dislocations: ____

Cardiac/Heart Problems: ___

Breathing/Lung Problems: ___

Frequent ear infections or ear tubes: ___

Difficulties with hearing: ____

Hearing tested? Yes __ No ___ Date (if yes): _____

Visual problems or glasses: ____

Gastrointestinal problems: ___

Other (please explain): _____

*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 ? _____

Is your child up to date with vaccines? Yes ____ No(explain below) ____

If any of above are checked 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: __ None __ My child is taking the following medications: (can attach additional sheet if needed)

_____

_____

_____

***I HAVE READ AND UNDERSTAND THE ATTENDANCE POLICY and AGREE TO EMAIL COMMUNICATIONS:**

Parent/Guardian Signature: _____

* if you wish to **opt out of email** communications **check here**: ☐

***I verify that the information provided above is accurate to the best of my knowledge.**

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

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

Attendance Policy reviewed with family. ☐ Standing appointments reviewed with family or not applicable. ☐

_____ _____

Therapist's Signature *Date*