

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): ____ Frequent ear infections or ear tubes: ____
Seizures: ____ Difficulties with hearing: ____
Hospitalizations: ____ Hearing tested? Yes ____ No ____ Date (if yes): ____
Surgeries or medical procedures: ____ Visual problems or glasses: ____
Broken bones or dislocations: ____ Gastrointestinal problems: ____
Cardiac/Heart Problems: ____ Other (please explain): ____
Breathing/Lung Problems: ____
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: _____

Commented [D1]:

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