Pediatrics/Adolescents

Health History Form

Date: _____

Patient Name: _____ DOB: _____ Height: _____ Weight: _____

Preferred Pronouns *(optional)*: ___She/Her ___He/Him ___They/Them ___Other: _____

Grade: _____ School Name: _____ Special Education or Assistance Needed: ☐ IEP ☐ 504 Plan

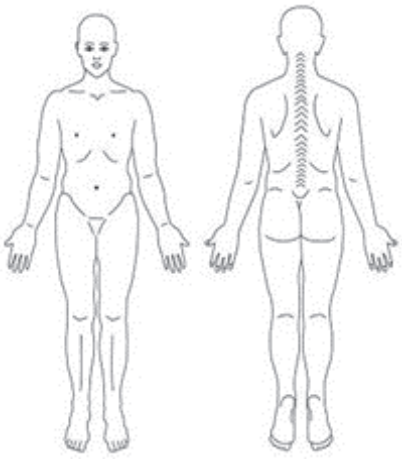
Primary Doctor: _____ Primary Concern(s): _____

_____

When were you first concerned? _____

Side of Injury: ☐Left ☐Right Date of Injury: _____ Have you had a similar injury?_____

Please circle or shade areas where you have pain:



Is your pain: ☐ Constant ☐Intermittent

Worse in: ☐AM ☐ PM

Does your pain wake you up at night? ☐ Yes ☐ No

Please rate your pain at ***rest***:

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain with ***activity***:

0 1 2 3 4 5 6 7 8 9 10

What eases your symptoms? _____

What increases your symptoms? _____

Level of activity: ☐ High ☐ Medium ☐ Low Define:_____

What activities are limited by this injury? _____

Have you had tests for this condition? ☐ X-Ray ☐ MRI ☐CT Scan ☐Blood Test ☐Other: _____

If yes, results: _____

Have you attended physical therapy before? ☐Yes ☐ No

What other health care providers are you currently seeing? (Check all that apply)

- ☐ Cardiologist / Pulmonologist
- ☐ Andiologist / ENT
- ☐ Psychologist / Psychiatrist
- ☐ Gastroenterologist / Nutritionist
- ☐ Opthamologist / Optometrist
- ☐ Neurologist
- ☐ Podiatrist
- ☐ Orthopedist / Orthotist
- ☐ Chiropractor
- ☐ SLP
- ☐ OT
- ☐ Counselor
- ☐ Other(s): _____

What are your goals for physical therapy? _____

_____

_____

Please continue on back page

Medical History / Allergies / Surgeries (Check all that apply) :

- ☐ Heart Complication(s)
- ☐ Ear / Sinus Infections
- ☐ Reflux / Vomiting / Nausea
- ☐ Seizures / Staring Spells
- ☐ Apnea
- ☐ Scoliosis
- ☐ Pneumonia
- ☐ Asthma
- ☐ Torticollis / Plagiocephaly
- ☐ Difficulty gaining weight / height
- ☐ Difficulty controlling bladder/bowel movements
- ☐ Delayed developmental milestones: motor, speech, feeding

Other: _____

_____

List Surgeries: _____

_____

_____

List Allergies: _____

_____

_____

Current Medications List

If you have a medication list, please bring it with you and we can make a copy.

Prescription and Over the Counter

Medication	Dosage	Frequency	Administration *Oral, topical, injection*

Vitamins / Minerals / Herbal Supplements

Name	Dosage	Frequency	Administration *Oral, topical, injection*