PEDIATRIC MEDICAL/SOCIAL HISTORY

West Texas Rehabilitation Center Medical Record #

Child's Name:	DOB:	Today's Date:

1. When was the last time the child was seen by a doctor?

2. What is the child's primary problem/concern that brings the child to West Texas Rehab?

3. How long has this problem been noticed?

4. How did this problem start?

❑ Result of specific injury/trauma ❑ Gradually ❑ Other (please explain)

5. Please indicate agencies below that are providing services for the child for health problems?

❑ECI ❑School District/Co-op ❑Private Therapist ❑Other (explain)

6. What is the primary goal for this child in therapy? What is the main area in need of improvement?

7. Has this child been treated at West Texas Rehab for anything before? ❑ Yes (explain below) ❑ No

If yes, when and for what?

8. Has this child been in the hospital? ❑ Yes (please explain below) ❑ No

Hospital	Dates	Reason

9. Below, please list the child's medications, which doctor is prescribing and that doctor's phone number.

❑ No Medications Currently ❑ See Attached List ❑ I do not remember and will bring a list with me next time.

Medication	Prescribing Physician	Physician's Phone Number

10. Is this child allergic to any medications? ❑ Yes (please list them below) ❑ No

For the following conditions, make a mark under the "P" if the child had this condition in the PAST or a mark under the "C" if the child CURRENTLY has the condition or the results of the condition.

P	C		P	C		P	C		P	C	
❑	❑	Asthma	❑	❑	Hearing Problems	❑	❑	Sensory Integration Disorder	❑	❑	Prematurity
❑	❑	Lupus	❑	❑	Vision Problems	❑	❑	Traumatic Brain Injury	❑	❑	Other (explain)
❑	❑	Diabetes	❑	❑	Chronic Bronchitis	❑	❑	Learning Disability			
❑	❑	Heart Disease	❑	❑	Bone Fracture	❑	❑	Muscular Disease			
❑	❑	Paralysis	❑	❑	Chronic Pain	❑	❑	Developmental Delay			
❑	❑	Stroke	❑	❑	Seizure Disorder	❑	❑	Orthopedic Problems			
❑	❑	ADD/ADHD	❑	❑	Ear Infection	❑	❑	Gastroesophageal Reflux (GERD)			

Where does the child spend most of his/her day?

❑ Home
❑ Day Care
❑ School
❑ Other (please explain)

Which of the following financial resources does the child's family have at this time?

❑ Employment
❑ Medicaid
❑ Insurance
❑ Pension
❑ Other (please explain)
❑ CHIP
❑ CSHCN (CIDC)
❑ Supplemental Security Income (SSI)
❑ No Income

All Languages spoken in the home, mark ALL that apply:

❑ English ❑ Spanish ❑ French ❑ German ❑ Other: _____ (specify)

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Are there problems with transportation? ❑ Yes (explain) ❑ No

Who lives in the child's home now?

Which of the following equipment does the child currently use?

❑ Oxygen
❑ Wheelchair
❑ Wheelchair Ramp
❑ Walker/Rolling Walker
❑ Crutches/Cane
❑ Hospital Bed
❑ Nebulizer
❑ Shower Bars
❑ Shower Chair/Bench
❑ Ventilator
❑ None
❑ Other (please explain)

What other equipment do you think the child might need?

Which of the following people help the child the most? *(check all that apply)*

❑ Parents ❑ Church Friends
❑ Friends/Neighbors ❑ Co-workers
❑ Brother/Sister ❑ Other Agency
❑ Other (list below) ❑ No one

Do these people need some extra help in order to meet the child's needs?

❑ Yes ❑ No ❑ Unsure

Is there anyone else with special needs in the child's home? ❑ Yes (please list them below) ❑ No

Please describe the mother's general health during the pregnancy, labor and delivery below.

Length of pregnancy:

Child's birth weight:

Please write the approximate age of the child when they began doing each of the following activities:

Crawling:	_____	Feeding self:	_____	Combining words:	_____
Walking:	_____	Standing:	_____	Naming simple objects:	_____
Using Toilet:	_____	Dressing self:	_____	Using simple questions:	_____
Sitting alone:		Using single words:		Engaging in conversation:	

Has the child ever had any feeding problems (sucking, swallowing, drooling, chewing, etc...)?* ❑ Yes ❑ No

**If yes, describe.*_____

1. Has the child lost weight within the last 3 months? ❑Yes ❑ No
2. Has the child had unexpected weight changes over the last 3 months? ❑Yes ❑ No
3. Has the child been eating/feeding less than usual with in the last 2 weeks? ❑Yes ❑ No

Please mark the appropriate box below that describes the child's response to sound:

❑ Responds to all sounds ❑ Responds ONLY to loud sounds ❑ Inconsistently responds to sounds

For each of the following activities, please place a mark if the child is limited in or has difficulty doing them.

❑ Bathing
❑ Dressing – Upper Body
❑ Dressing – Lower Body
❑ Eating ☐ fruits ☐ vegetables ☐ meat/protein
❑ Hand Dominance ☐ L ☐ R ☐ not established
❑ Swallowing
❑ Grooming
❑ Walking ∧ ❑ Indoors ❑ Outdoors
❑ Standing ∧ ❑ Under 15 mins ❑ Over 15 mins
❑ Lifting ∧ ❑ Waist Level ❑ Overhead
❑ Sitting ∧ ❑ Under 15 mins ❑ Over 15 mins
❑ Sleeping ∧ ❑ On their back ❑ On their stomach ❑ On their left side ❑ On their right side
❑ Climbing
❑ Sitting Alone
❑ Toileting
❑ Stairs
❑ Speaking
❑ Hearing
❑ Problem Solving
❑ Other (please explain)

Do you currently have an Advanced Directive or Universal Do-Not-Resuscitate Order?* ❑ Yes ❑ No

**If yes, please provide a copy for our records.*

Name of person that completed this form: (please print)

Signature of person that completed this form:

Relation to patient: