Allegretto Therapy Services, LLC

Pediatric Medical History Form

Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

Child’s Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL INFORMATION**

**What is the child’s sex?**  ☐ Female ☐ Male

**Child’s Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ current age

**MEDICAL HISTORY**

Is your child on any medication?

If so, list here:

Does you child have any food or drug allergies?

If so, list here:

Has your child ever been a **patient** **in a hospital** (other than a few days after birth)?

☐ No (If no, go to question #4.)

☐ Yes (If yes, explain why and when below.)

|  |  |
| --- | --- |
| **My child was in the hospital because:** | **When** |
| **Example:**  Bike accident | 5 years old |
|  |  |
|  |  |
|  |  |
|  |  |

Please check any of the following **medical problems** that your child has **ever** had.

|  |  |
| --- | --- |
| Has your child **ever** had**:** |  |
| **Ear** infections | ☐ Yes ☐ No |
| **Nose** problems (sinus infections, nose bleeds) | ☐ Yes ☐ No |
| **Eye** problems (blurry vision, need to wear glasses) | ☐ Yes ☐ No |
| **Hearing** problems | ☐ Yes ☐ No |
| **Mouth or throat** problems (Strep throat, swallowing problems) | ☐ Yes ☐ No |
| **Diarrhea** (having frequent and runny bowel movements/poop) | ☐ Yes ☐ No |
| **Constipation** (problems having a bowel movement /poop) | ☐ Yes ☐ No |
| **Throwing up** (vomiting) | ☐ Yes ☐ No |
| Problems **peeing** (bed wetting, pain when peeing) | ☐ Yes ☐ No |
| **Back** problems (crooked back, back pain) | ☐ Yes ☐ No |
| **Growing pains** (bone or body pains due to growing) | ☐ Yes ☐ No |
| **Muscle and bone** problems (weak muscles, pain in joints) | ☐ Yes ☐ No |
| **Skin** problems (acne, flaking skin, rashes, hives) | ☐ Yes ☐ No |
| **Seizures** (shaking fits) | ☐ Yes ☐ No |
| **ADD/ADHD** (problems paying attention, sitting still) | ☐ Yes ☐ No |
| **Sleeping** problems (falling or staying asleep) | ☐ Yes ☐ No |
| **Breathing** problems (cough, asthma) | ☐ Yes ☐ No |
| **Warts** | ☐ Yes ☐ No |
| **Jaundice** (yellow skin) | ☐ Yes ☐ No |

**ABOUT MOM WHEN PREGNANT**

The following questions are about the mother of the child during pregnancy and birth.

If you do not know about the pregnancy of the mother, check here ☐ and go to question #17.

What was the general **health of the mother** during pregnancy?

☐ Excellent ☐ Good ☐F air ☐ Poor ☐ Unknown

Did the mother have any of the following **conditions or problems during pregnancy**?

☐ Preeclampsia (high blood pressure) ☐ Diabetes (sugar)

☐ Emotional stress ☐ Injury or serious illness

☐ Unexpected bleeding or spotting ☐ Other

**Was the birth**:

☐ On the due date

☐ Before the due date (by how much\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

☐ After the due date (by how much\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Were there any **problems during the birth**? ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_\_\_\_

At what age did the child begin to **crawl**? \_\_\_\_\_\_\_\_\_\_\_\_

At what age did the child begin to **sit up**? \_\_\_\_\_\_\_\_\_\_\_\_

At what age did the child begin to **walk**? \_\_\_\_\_\_\_\_

At what age did the child get his/her **first tooth**?

At what age did the child began to **say words** (mama, dada)?

How would you rate your **child’s health in his or her first year** of life?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Unknown

What are your ST/OT/PT concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_