INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET
Pediatric (page 1)

Patient Name: _____ Date of Birth:_____ Date of Eval: _____

SUBJECTIVE

Why are you seeking treatment for your child? _____

_____

_____

Has your child had any prior treatment and/or diagnostic testing for this condition? □ Yes □ No

If Yes: □ X-rays □ MRI □ EMG/Nerve Conduction Test

Other:_____

If Yes, please explain: _____

_____

Date of next Doctor's appointment: _____

THERAPIST USE ONLY: I have reviewed the information provided and: ☐ Information is complete ☐ Additional comments below

Subjective History: _____

_____

_____

_____

_____

_____

_____

CURRENT COMPLAINTS

What are your main concerns regarding your child?

□ Fine Motor (i.e., handwriting, buttoning) □ Mobility □ Feeding □ Behavior □ Other: _____

□ Gross Motor (i.e., walking, kicking a ball □ Speech □ Language □ Other: _____

THERAPIST USE ONLY: I have reviewed the information provided and: ☐ Information is complete ☐ Additional comments below

Other Related Information: _____

_____

_____

_____

_____

_____

PREGNANCY AND BIRTH HISTORY

Were there any complications during pregnancy? □ Yes □ No Comments: _____

Was the pregnancy full term? □ Yes □ No Comments: _____

Were any drugs or medications taken during pregnancy? □ Yes □ No Comments: _____

Was labor and delivery normal? □ Yes □ No Comments: _____

Please list birth weight and length: _____

THERAPIST USE ONLY: I have reviewed the information provided and: ☐ Information is complete ☐ Additional comments below

Other Related Information: _____

_____

_____

_____

Patient Name: _____ Date of Birth:_____ Date of Eval: _____

GROWTH AND DEVELOPMENT

At what age did your child:

- □ **Roll over from stomach to back? _____**
- □ **Roll over from back to stomach? _____**
- □ **Sit Independently?_____**
- □ **Crawl? _____**
- □ **Walk holding onto furniture? _____**
- □ **Walk independently? _____**
- □ **Speak first word? _____**
- □ **Speak in 2 word sentences? _____**
- □ **Drink from cup? _____**
- □ **Use a spoon? _____**
- □ **Dress independently?_____**
- □ **Toilet train? _____**

Please describe your child:

□ **Mostly Quiet**	□ **Tires Easily**	□ **Talks Constantly**	□ **Clumsy**	□ **Happy**
□ **Impulsive**	□ **Overly Active**	□ **Overreacts Frequently**	□ **Shy**	□ **Restless**
□ **Craves Touch**	□ **Impulsive**	□ **Gets Frustrated Easily**	□ **Stubborn**	□ **Has Temper Tantrums**
□ **Difficulty Separating**	□ **Has Nervous Habits**	□ **Has Unusual Fears**	□ **Avoids Touch**	□ **Has Poor Attention Span**
□ **Difficulty Learning New Tasks**		□ **Other**:_____		

THERAPIST USE ONLY: I have reviewed the information provided and: ☐ Information is complete ☐ Additional comments below

Other Related Information: _____
_____
_____

PREVIOUS MEDICAL HISTORY

How would you classify your child's general health? □ **Good** □ **Fair** □ **Poor**

Please check ALL that apply:

□ Allergies	□ Encephalitis	□ Multiple Sclerosis	□ Rheumatic Fever
□ Asthma/Breathing Difficulties	□ Enlarged Glands	□ Nausea/Vomiting	□ Ringing of the Ears
□ Bronchitis	□ Fever	□ Night Pain	□ Seizures/Epilepsy
□ Cancer	□ Head Injury	□ Osteoarthritis	□ Sinusitis
□ Chest Pain/Angina	□ Headaches	□ Osteoporosis	□ Smoking History
□ Chicken Pox	□ Heart Disease	□ Pacemaker	□ Stroke/TIA
□ Chronic Colds	□ High Blood Pressure	□ Parkinson's Disease	□ Surgeries
□ Chronic Laryngitis	□ Hypoglycemia	□ Physical Abnormalities	□ Thyroid Disease
□ Congenital Defects	□ Measles	□ Pneumonia	□ Tonsillitis
□ Depression	□ Meningitis	□ Polio	□ Tuberculosis
□ Diabetes: Type I or II	□ Metal Implants	□ Pregnancy (Currently)	□ Whooping Cough
□ Dizziness/Fainting	□ Mumps	□ Rheumatoid Arthritis	

Is there any other information regarding your child's medical history that we should know about? _____
_____
_____

Does your child have any of the following? If Yes, please explain in the space provided:

- □ **Earache/Ear Infection** **Describe: _____**
- □ **Hearing Difficulties** **If Yes, Aided? _____**
- □ **PE Ear Tubes Inserted** **Describe: _____**
- □ **Vision Problems** **If Yes, Treatment? _____**

Have you ever purchased or rented Durable Medical Equipment, Orthotics, Prosthetics, or Supplies?

□ **Yes** □ **No** **Explain: _____**

THERAPIST USE ONLY: I have reviewed the information provided and: ☐ Information is complete ☐ Additional comments below

Please List Previous Medical History or Co-Morbidities that May Impact Rate of Recovery: _____
_____
_____

Patient Name: _____ Date of Birth:_____ Date of Eval: _____

MEDICAL PRECAUTIONS/CONTRAINDICATIONS

Are there any factors that may complicate your child's ability to participate in therapy? □ Yes □ No
If Yes, please explain: _____
_____
Does your child have food allergies? □ Yes □ No
If Yes, please list: _____
Does your child have any movement restrictions? □ Yes □ No
If Yes, please list: _____

THERAPIST USE ONLY: I have reviewed the information provided and: ☐ Information is complete ☐ Additional comments below
Other Related Information: _____
_____
_____

MEDICATIONS

Please list all of the medications [*with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)*] that you are currently taking [including over-the-counter, prescriptions, herbals, and vitamins/mineral(s)]: _____
_____
_____

COMMUNICATION HISTORY

Please describe any communication difficulties: _____
_____
_____
When was the problem first noticed? _____
Other language(s) besides English spoken in the home: _____

THERAPIST USE ONLY: I have reviewed the information provided and: ☐ Information is complete ☐ Additional comments below
Other Related Information: _____
_____
_____

SOCIAL HISTORY/INTERESTS/LIVING ENVIRONMENT

Father's Name: _____ Age: _____ Occupation: _____
Mother's Name: _____ Age: _____ Occupation: _____

Is he/she adopted? ☐ Yes ☐ No If Yes, at what age? _____

Parent's Marital Status ☐ Married ☐ Living Together ☐ Separated ☐ Divorced ☐ Remarried
Who lives in the house with this child? _____

THERAPIST USE ONLY: I have reviewed the information provided and: ☐ Information is complete ☐ Additional comments below
Other Related Information: _____
_____
_____

Patient Name: _____ Date of Birth: _____Date of Eval: _____

EDUCATIONAL HISTORY

Does your child attend school? □ Yes □ No
If Yes, where?_____
What grade is he/she in? _____

Has your child ever repeated a grade? □ Yes □ No
If Yes, what grade(s)?_____

Does your child have Special Education or Therapy services <u>in school</u>? □ Yes □ No
If Yes, what services? □ Physical Therapy □ Occupational Therapy □ Speech Therapy
How often? _____ How long? _____
Individual/group? _____
Additional Comments: _____

Has your child received Therapy anywhere else? □ Yes □ No
If Yes, what services? □ Physical Therapy □ Occupational Therapy □ Speech Therapy
Where? _____
By whom? _____
Additional Comments: _____

Are there any religious or cultural issues that we should be aware of regarding your child's evaluation? _____
_____

PATIENT GOALS FOR THERAPY

What goals are you hoping to have your child accomplish by participating in Therapy? _____
_____
_____

ADDITIONAL RELEVANT INFORMATION

THERAPIST USE ONLY:_____
_____
_____
_____
_____
_____
_____
_____
_____

GUARDIAN SIGNATURE

To the best of my knowledge I have fully informed you of the history of my child's problem and current status.

Patient Guardian's Signature: _____ Date: _____

Relationship to Patient:_____

THERAPIST SIGNATURE

The above information represents all significant subjective findings.

Please refer to the enclosed Objective Findings and Plan of Care for my assessment, treatment goals, and treatment plan.

Therapist's Signature: _____License # _____ Date: _____

Printed Therapist's Name: _____