Quest

BOZEMAN HEALTH DEACONESS HOSPITAL

Patient Label
Name: _____
DOB: _____
M#:_____

Pediatric Rehabilitation Intake Form

(Please complete all pages)

Patient Information:

Name: _____
Last First Middle

Gender: _____ **Date of Birth:** _____

Physician: _____**Referred By:** _____

Daycare/Preschool/School: _____**Grade**: _____

Any known diagnoses: _____
_____

Family Information:

Parent/Guardian (1): _____ **Relationship:** _____

Occupation: _____ **Phone:** _____

Address: _____

E-mail: _____

Parent/Guardian (2): _____ **Relationship:** _____

Occupation: _____ **Phone:** _____

Address: _____

E-mail: _____

Where and with whom does this child live most of the time? _____

Does your child stay anywhere other than the primary residence? (i.e. joint custody)_____
_____

Is this child: ❑ Natural Child ❑ Adopted ❑ Foster ❑ Step Child ❑ Other: _____

Age at the time of adoption/length in foster care: _____

Name/Age of other children in the family: _____

Who has permission to pick this child up from therapy?_____

_____

Are there any other factors that may affect your child's ability to attend therapy sessions? (i.e. transport, finances, etc.) _____

Birth History:

Location of Birth: _____ **Delivery Method:** ❑ Vaginal ❑ C-Section

Length of Pregnancy: _____**Weight at Birth:** _____

Prenatal Complications: _____

Did the mother use alcohol or drugs during pregnancy? ❑ Yes ❑ No
If "yes," were the drugs prescription or recreational? _____

Did your child require special care as a newborn? _____

Health History:

Circle all that apply:

- Convulsions
- Feeding problems
- Congenital problems
- Head injury
- Vision problems
- Unexplained high fever
- Sleep pattern disturbances
- Meningitis
- Frequent ear infections
- Hearing problems
- Other: _____

Please explain any of the circled above:

_____

_____

Does your child have any allergies? _____

Has your child ever has a reaction to rubber (latex) products? _____

Medications child is currently taking: _____

Prior surgeries/hospitalizations: _____

Has your child ever received, or currently involved in any Special Services? (i.e. Speech, Occupational, Physical therapy) ❑ Yes ❑ No
If "yes," where, when and how long? _____
If "yes," may we contact them? ❑ Yes ❑ No

Are there any other health agencies involved in your child's care? (i.e. Family Outreach, DSHS, CPS)
❑ Yes ❑ No If "yes," please describe: _____

Health History: *(Continued)*

Please describe any concerns you may have regarding your child's development in any of the following areas:

	No Concern	**Concerns** (describe)
Eating	_____	_____
Sleeping	_____	_____
Attention	_____	_____
Hearing	_____	_____
Vision	_____	_____
Coordination	_____	_____

Has your child's hearing or vision been evaluated? ❑ Yes ❑ No

If "yes," when and where? _____

Developmental History:

Please indicate age accomplished, and describe any problems with the following:

Activity	**Age**	**Problem/Comments**
Lifted head when on stomach	____	_____
Rolled back to stomach	____	_____
Held own bottle	____	_____
Sat unsupported	____	_____
Crawled	____	_____
Walked unsupported	____	_____
Bladder trained	____	_____
Bowel trained	____	_____
First words	____	_____
Combined words into short sentences	____	_____
Demonstrated hand preference	____	_____
Dressed self	____	_____
Tied shoelaces	____	_____
Rode bicycle	____	_____

Does your child have one of the following? ❑ **IEP** ❑ **504 Plan**