Bloomington Hospital

Children's Therapy Center
Pediatric Medical/Social History

Patient Identification Area
(label, cardoplate, etc.)

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY

Was your child premature? ☐ No ☐ Yes – Number of weeks premature _____

Are there any details/complications about pregnancy or delivery you would like us to know?

☐ No ☐ Yes _____

Past procedures or testing relevant to today's visit: _____

_____

Current or previous therapies? ☐ No ☐ Yes _____

Is your child experiencing or complaining of pain? ☐ No ☐ Yes

If yes, please describe: _____

Does your child have any allergies or adverse reactions? ☐ No ☐ Yes, see attached list

Is your child currently taking any medications? ☐ No ☐ Yes, see attached list

SOCIAL HISTORY

What is your child's first/primary language? _____

Do you have any religious or cultural beliefs/practices we need to consider in your child's care? ☐ No ☐ Yes

Are you concerned about you or your family's level of anxiety and/or coping ability? ☐ No ☐ Yes

Do you feel you need any outside/community services? ☐ No ☐ Yes

Is there anything that would limit your ability to return for follow – up visits? ☐ No ☐ Yes

If yes, please describe: _____

Is anyone at home, work, or school harming you or your child? ☐ No ☐ Yes _____

Does your child attend daycare? ☐ No ☐ Yes – Name of daycare: _____

Does your child attend preschool/school? ☐ No ☐ Yes, at _____ Grade _____

If yes, does your child have a current IEP (Individual Education Plan)? ☐ No ☐ Yes

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What is your preferred learning style (check all that apply)? ☐ Verbal ☐ Visual/Written ☐ Demonstration

☐ Other _____

Is there anything that may limit you or your child's ability to learn? ☐ No ☐ Yes _____

If yes, please describe: _____

How would you prefer we communicate with you?

☐ Phone ☐ Email ☐ No preference/either phone or email

What concerns do you have about your child's development? – Please check all that apply:

☐ Fine Motor Skills	☐ Feeding	☐ Gross Motor Skills
☐ Visual – Perceptual Skills	☐ Nutrition	☐ Clumsy/Falls Often
☐ Sensory Issues	☐ Cognitive Skills	☐ Equipment
☐ Self–Care Skills	☐ Self–Control	☐ Movement (upper extremity)
☐ Handwriting	☐ Communication	☐ Movement (lower extremity)
☐ Two–handed tasks	☐ Attention Span	☐ One side of body: Right
☐ Positioning	☐ Play skills/social interaction	☐ One side of body: Left

Please describe above concerns in detail: _____

_____

Are there any other concerns you would like to discuss privately with your child's therapist?

☐ No ☐ Yes _____

The above information reflects my child's current health status and past medical history.

_____ _____
Patient/Parent/Legal Guardian's Signature Date

_____ _____ _____
Clinician Signature Date Time

_____ _____ _____
Clinician Signature Date Time

_____ _____ _____
Clinician Signature Date Time