Total Health

OFFERED BY STILLWATER MEDICAL CENTER

Pediatric Intake

DATE: ____ /____ /_____

GENERAL INFORMATION:

PATIENT NAME:		DATE OF BIRTH:
MOTHER'S NAME:		
MOTHER'S CONTACT INFO: HOME #:	CELL #:	WORK #:
FATHER'S NAME:		
FATHER'S CONTACT INFO: HOME #:	CELL #:	WORK #:
MOTHER'S EMAIL ADDRESS:	FATHER'S EMAIL ADDRESS:	
MAY WE CALL YOU DURING THE DAY? ☐ YES ☐ NO	IF YES, WHO SHOULD BE CALLED? ☐ MOTHER ☐ FATHER	
WHO WILL BRING THE CHILD TO THERAPY? NAME:		RELATIONSHIP:
OTHER CAREGIVER'S INVOLVED:		
REFERRING PHYSICIAN:	PRIMARY CARE PHYSICIAN:	
RETURN TO DOCTOR DATE:	ONSET DATE OF SYMPTOMS:	

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY

- Patient Barriers?

☐ Visual ☐ Cognitive/Verbal ☐ Cognitive/Written ☐ Age related
☐ Cultural ☐ Ethnical ☐ Emotional ☐ Auditory
☐ Reading Skills ☐ Motivation ☐ Language ☐ Spiritual
☐ Stress ☐ Physical ☐ Financial

- Please state your child's best learning method:

☐ Demonstration ☐ Discussion ☐ Pictures ☐ Verbal ☐ Written

CURRENT PATIENT INFORMATION:

- Current Weight:_____ • Current Length: _____ • Weight at Birth: _____ • Length at Birth: _____
- Gestational Age:_____ • Was child born prematurely? ☐ Yes ☐ No If yes: Weeks gestation? _____
- Was child breastfed? ☐ Yes ☐ No • Length of Time: _____ • Mom's age at time of birth: _____
- Was your child admitted to NICU or did he/she remain in newborn nursery? _____
- Did you child receive therapy services prior to returning home (in NICU, PICU, or nursery)? ☐ Yes ☐ No
- Any previous therapy service provided in school/outpatient? ☐ Yes ☐ No
- Utero Position: _____• Infant position at birth: ☐ Vertex/ ☐ Breech/ ☐ Transverse/ ☐ Other:_____
- Attendance at a pre-Natal Class: ☐ Yes ☐ No • Was infant active? ☐ Yes ☐ No
- Did the infant seem stuck in one position for the past part of pregnancy? ☐ Yes ☐ No
- How many weeks was the infant stuck? ☐ Vertex / ☐ Breech / ☐ Transverse _____weeks
- First Child? ☐ Yes ☐ No • ☐ Single / ☐ Multiple Birth: ☐ Twin A / ☐ Twin B

- List any complications during pregnancy (bed rest / low back pain / leg pain): _____
_____
- List any complications during delivery: _____
- List any medication taken by mother during pregnancy & delivery:_____
_____
- Has child ever been treated for torticollis? ☐ Yes ☐ No
- Has child ever been treated for any other diagnosis? ☐ Yes ☐ No If yes, please name:_____
_____
- Diagnostic Test: ☐ Xray ☐ MRI ☐ CT Scan ☐ US
- Child's sleep position: ☐ Supine (on back) ☐ Side ☐ Prone (on tummy) ☐ Other:_____
- If applicable, does your child snore? ☐ Yes ☐ No • Does your child have frequent ear infections? ☐ Yes ☐ No
- Please list the age of child at the following milestones (in months):

  Started Walking: _____ Started Talking: _____ Eating Table Food: _____

  Mouthing of toys/hands: _____ Cereal introduced: _____ Pacifier use: _____

  Dress self: _____ Toilet train: _____
- Did your infant have trouble feeding? ☐ Yes ☐ No If yes: ☐ Breast (☐ left/ ☐ right) ☐ Bottle Feeding
- Jaundice? ☐ Yes ☐ No • Reflux? ☐ Yes ☐ No Medication: _____
- What kind of food/formula does your child eat? _____
- Who lives at home with the patient? ☐ Parents ☐ Grandparents ☐ Siblings ☐ Others: _____
- How does you child typically communicate? Choose one: ☐ Gestures ☐ Single words ☐ Short phrases ☐ Sentences
- Is your child understood by others or just family members?_____
- Where do you generally seek information on your child's development? _____
- Did you infant have a normal head shape at birth? ☐ Yes ☐ No If no, describe: _____

_____
- Who noticed the misshapen head? _____ • What age? _____
- Time child spends in car seat carrier per day?_____ • Type used? _____
- Time child spends in swing per day?_____
- Other infant sitting devices used an time spent in them per day? _____
_____
- Time child spends on back daily: _____ • Time spent on belly daily: _____ • Age Belly time initiated:_____
- Does your infant have a head tile preference: ☐ Left ☐ Right • Rotation preference: ☐ Left ☐ Right
- Any other children with tight neck muscles and/or misshapen head? ☐ Yes ☐ No
- Do you notice any facial asymmetry? ☐ Yes ☐ No If yes, describe:_____
- Congenital Anomalies:

  ☐ Hip dysplasia / ☐ Hip subluxation: ☐Left / ☐Right ☐ Facial palsy: ☐Left / ☐Right

  ☐ Fractured clavicle: ☐Left / ☐Right ☐ Brachial plexus injury: ☐Left / ☐Right

  ☐ Forceps abrasion: ☐Left / ☐Right ☐ Fractured Clavicle: ☐Left / ☐Right

  ☐ Cephalohematoma: ☐ Parietal: (☐Left / ☐Right) ; (☐Small / ☐Medium / ☐Large)

  ☐ Occipital: (☐Left / ☐Right) ; (☐Small / ☐Medium / ☐Large)

- List activities your child is having difficulty performing? _____

_____

_____

_____

FM/ HANDWRITING

- Which is your child's dominant hand? ☐ Right ☐ Left ☐ Unknown
- Does your child have difficulty with clothing fasteners? ☐ Yes ☐ No If yes, explain: _____

_____

- Does your child complain of hand pain/fatigue with writing? ☐ Yes ☐ No If yes, explain: _____

_____

- Can your child write his/her name? ☐ Yes ☐ No
- Can your child copy simple shapes? (circle, square, triangle)? ☐ Yes ☐ No