SPAULDING™
EILEEN M. WARD
OUTPATIENT CENTER
for Children
SANDWICH

PATIENT IDENTIFICATION AREA

PATIENT GENERAL HEALTH FORM

(Please fill out every section to the best of your ability. If you have any questions please ask your evaluating therapist.)

PEDIATRIC PATIENT GENERAL HEALTH FORM

Patient Name:_____**Age**:_____

Daycare/School and Address: _____
How many days/ hours per week is your child at Daycare/School: _____

Have teachers or other care providers expressed concerns: ❑ Yes ❑ No (If yes, please explain below.)

_____

_____

❑IEP ❑ 504 plan ***Please provide IEP/504 plan if available***
Has your child received rehabilitation/ habilitation services previously? (ie: school based PT/OT/SLP, ABA, early Intervention): ❑ Yes ❑No (If yes, please list below and provide copies of evaluations if available.)

Name of Facility/Organization/Provider/Discipline	**Frequency:**	**From: ____ to: _____**
Example: Spaulding Center for Children/OT	*1x /week*	*June 2015 to present*

List of Medical Doctors/Specialist:

MD	**Name**	**Contact Information**
Primary Care Physician		
Referring MD		
Neurologist		
Cardiologist		
Orthopedist		
Surgeon		
Other:		

Reason for Referral: _____

_____

Primary concerns: _____

_____

Goals for therapy: _____

_____

Precautions: (ie: Orthopedic, Cardiac, Diet): _____

_____

Allergies: _____

Please list any and all medications currently prescribed, and what the medication is prescribed to treat.

Medication Name:	**Dosage:**	**What is it treating:**
Example: Albuterol	2x daily	Asthma

SPAULDING™
EILEEN M. WARD
OUTPATIENT CENTER
for Children
SANDWICH

PATIENT IDENTIFICATION AREA

PATIENT GENERAL HEALTH FORM

PEDIATRIC PATIENT GENERAL HEALTH FORM

Other current or past diagnoses: ❑ yes ❑no
If yes, please complete chart below

Illness/Condition	Age	Severity (Mild, Mod, Severe)	Illness/Condition	Age	Severity (Mild, Mod, Severe)
Lyme's Disease			Lead Exposure		
Chronic Colds			Arthritis		
Middle Ear Infections			Spina Bifida		
Allergies			Congenial Birth Defect		
Asthma			Difficulty Swallowing		
Pneumonia			Club Foot		
Tonsillitis			Autism/PDD		
Meningitis			Stuttering		
Encephalitis			Voice Problems		
Seizure Disorder			Fear of loud noises, movement, touch		
ADHD/ADD			Behavior Issues		
Learning Disability			Psychological Issues		
Hearing Loss			Other		

Any other significant medical history including hospitalizations, surgeries, injuries, etc: _____
_____
Has anyone else in your family been treated for a similar condition? _____
_____

DEVELOPMENTAL:
Complications with Pregnancy/Delivery: _____
_____
Condition at birth and treatment required: _____
_____
Exposure to harmful substances in utero? ❑ Yes ❑No
If yes, what substance? _____
Birth Weight: _____
Immunizations up to date: ❑Yes ❑No
Name of provider who holds immunization record: _____

At what age did your child do the following:(not applicable for sports related/ orthopedic injuries)

Milestone	Age	Milestone	Age
Focus on an Object		Crawl	
Reach for a toy		Feed Self	
Say first word		Sit unsupported	
Walk		Roll over	
Produce 2 word phrase		Sit unsupported while using a toy	

Do you have any feeding concerns? ❑Yes ❑No (If yes, check below)
❑ My child only eats foods of certain colors or textures ❑ My child gags at the sight or smell of certain foods
❑ My child has difficulty using utensils ❑ My child drools more than others ❑ My child has or had a g-tube

Has your child's hearing been tested? ❑Yes ❑No When? _____
Results: ❑Typical ❑Further Testing Required ❑Hearing Aid ❑Other:

Has your child's vision been tested? ❑Yes ❑No When? _____
Results: ❑Typical ❑Further Testing Required ❑Glasses ❑Other:

SPAULDING™
EILEEN M. WARD
OUTPATIENT CENTER
for Children
SANDWICH

PATIENT IDENTIFICATION AREA

PATIENT GENERAL HEALTH FORM

PEDIATRIC PATIENT GENERAL HEALTH FORM

Members of the child's primary household:		
Name:	Age:	Relationship:
Members of the child's secondary household if applicable:		
Name:	Age:	Relationship:
Other pertinent family members/caregivers:		
Name:	Age:	Relationship:

Screening for Abuse and Neglect:
Do you suspect your child has been physically, sexually, or emotionally abused? ❑Yes ❑No

_____	_____	_____	_____	_____	_____
Parent/Guardian Signature	Date	Time	Therapist Signature	Date	Time