MADONNA THERAPYPLUS
Physical and Occupational Therapy
An outpatient clinic of Madonna Rehabilitation Hospital

Pediatric Medical History Questionnaire

To better serve you and your child's individual needs, please complete the following and check appropriate choices when indicated.

Child's name (please print)**:** ______________________________

1. Main reason for needing therapy: ______________________________
   Date of injury or onset: _____/_____/________
2. Birth History: (pregnancy related, complications with labor & delivery, APGARs after birth, need for oxygen) ______________________________
   ____
   ____
3. Pediatrician: ______________________________
4. Other physicians involved in your child's care: ______________________________
   ____
5. Has your child received therapy before? ☐ Yes ☐ No When? ______________________________
6. Any previous surgeries or medical procedures? ☐ Yes ☐ No
   Date/Type: ______________________________
   ____
   Precautions: ______________________________
7. What tests have been done? ☐ X-ray ☐ MRI ☐ CT Scan ☐ Swallow Study ☐ EMG
   ☐ PET Scan ☐ Other: ______________________________
   Findings: ______________________________
8. Is your child able to sleep through the night? ☐ Yes ☐ No
9. What is the frequency of your child's bowel movements? ______________________________
10. Developmental Milestones Achieved:
    Talking: ☐ Not age appropriate ☐ Age achieved: __________ ☐ Unsure
    Rolling: ☐ Not age appropriate ☐ Age achieved: __________ ☐ Unsure
    Sitting: ☐ Not age appropriate ☐ Age achieved: __________ ☐ Unsure
    Walking: ☐ Not age appropriate ☐ Age achieved: __________ ☐ Unsure
11. Child/Family Goals and Preferences: ______________________________
    ____
    ____
12. Child/Family Adjustment to Activity Limitations: ______________________________
    ____
    ____
13. Support Available (siblings, caregivers, peers, professional organizations): ______________________________
    ____
14. Child's favorite toys, songs, games: ______________________________
    ____
15. Does your child have any fears or sensitivities: ☐ Yes ☐ No
    If yes, what are they? ______________________________
16. School/Work Related Issues: ______________________________
    School/Daycare Attending: ______________________________ Grade: __________
17. Does your family practice any cultural traditions that you would like us to be aware of?
    ☐ Yes ☐ No If yes, what are they? ______________________________
    What is the primary language used in the home? ______________________________
18. Please answer the following if your child is age appropriate.
    Is there a history of alcohol or drug abuse? ☐ Yes ☐ No ☐ Not age appropriate
    If yes, please explain: ______________________________
    ____
    Is your child sexually active: ☐ Yes ☐ No ☐ Not age appropriate
    If yes, please state any concerns: ______________________________

Pediatric Medical History Questionnaire

Allergy Information	
Latex allergy? ☐ Yes ☐ No	
Other Allergies:	Type of Reaction:

Medication Information			
Medication Name	Reason for Taking Medication	Prescribing Physician	Physician Phone Number

☐ See attached medication list, which includes the physician name and telephone number.

____
Child's name (please print)

____
Parent/Guardian name (please print)

____ _____________ ________
Parent/Guardian signature Date Time