BreakThrough Pediatric Therapy

Background Information and Medical History

In order to ensure your child receives a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave the area blank and your therapist can assist you.

PATIENT'S NAME_____ DOB:_____

PEDIATRICIAN:_____ PRACTICE:_____

Is your child currently under the care of any of the following:

YES	NO	ORTHOPEDIST	YES	NO	OSTEOPATH
YES	NO	NEUROLOGIST	YES	NO	PSYCHIATRIST/PSYCHOLOGIST
YES	NO	PHYSICAL THERAPIST	YES	NO	SPEECH LANGUAGE THERAPIST
YES	NO	OCCUPATIONAL THERAPIST	YES	NO	CHIROPRACTOR
YES	NO	PHYSIATRIST	YES	NO	OTHER_____

If your child has been seen by any of the above in the last 3 months, please describe for what reason (illness, medical condition, etc)_____

_____

Were there any complications during your pregnancy?_____

Was your child born prematurely? **YES NO** If yes, how many weeks gestation?_____

Did your child stay in the NICU? **YES NO** If yes, for how long?_____

Has your child had any surgeries or other hospitalizations?

DATE SURGERY/HOSPITALIZATION REASON_____

_____

_____

_____

_____

_____

PLEASE LIST ANY PRESCRIPTION MEDICATIONS TH AT YOUR CHILD IS TAKING (includin g pills, injections, patches, or via pump)

_____

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS:

YES NO HYDROCEPHALUS_____

YES NO HEART PROBLEMS_____

YES NO EPILEPSY OR OTHER SEIZURE DISORDER_____

YES NO LUNG DISEASE_____

YES NO STROKE_____

YES NO HEARING DISORDER/LOSS_____

YES NO MUSCLE DISEASE OR DISORDER_____

YES NO EYE DISEASE OR VISION LOSS_____

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YES NO ASTHMA OR REACTIVE AIRWAY DISEASE_____
YES NO DIABETES_____
YES NO CANCER_____
YES NO SENSORY DYSFUNCTION_____
YES NO OTHER_____

Does your child have any allergies? If yes, please explain:

_____

_____

Does your child have difficulties falling asleep or remaining asleep? If yes, please explain: _____

_____

_____

Please list and explain relationships of members living in the same household with your child: _____

_____

_____

Does your child have feeding problems or aversions to any food/textures? If yes, please explain: _____

_____

_____

Please describe any hobbies or activities that your child enjoys: _____

_____

Has your child been evaluated at the CDSA for early intervention services? YES NO
If so, did your child qualify for services? YES NO Name of Case Manager:_____

Does your child have a Medicaid or other insurance Case Manager? YES NO
If so, please provide their name:_____
Does your child have a CAP Case Manager? YES NO Name:_____

Does your child regularly attend daycare, preschool, or WCPSS? Please Specify:_____

Is there any other information not included in this form that may be helpful for the therapist to know about your child and his/her condition? _____

_____

_____

_____

Form reviewed with patient's parent or guardian? YES NO

_____ _____
Therapist Signature Date