rehabilitation services – patient information

Date: ___________ **Patient's name:** ____ **Date of birth:**____________
Legal first Middle Last

Person completing this form: ___________________________________ Relationship to patient: _________________

During your first visit, we review the answers on this form. This helps us decide what tests we need to do. Your comments are very important. If possible, please complete this information at home and bring it with you to your first session.

Thank you in advance for this information.
Please bring your referral and insurance information to your first visit.
If you have any questions or concerns before your visit, please feel free to call us.

Cook Children's Medical Center 682-885-4063	Cook Children's South Rehab Clinic 682-885-4063	Cook Children's Child Study Center 682-885-2190	Cook Children's Mansfield Rehab 682-885-2200	Cook Children's Northeast Rehab 817-581-2794

Your requests and thoughts:

What is the reason for this therapy visit? (Please list specific problems or behaviors.) ___________________________

What do you hope to accomplish with therapy?____

Please list customs, religious beliefs or wishes that we need to know about? __________________________________

During treatment, we will give you directions for practicing activities at home. Do you have a favorite way of learning new information? ☐ Pictures ☐ Written ☐ Demonstration ☐ No preference

Please list any other concerns that you would like us to know: ____

Birth information:

☐ Yes ☐ No Was the patient born after a full-term pregnancy?
If no, how early? ___________ What was the patient's birth weight? _______

☐ Yes ☐ No Were there any complications during pregnancy or delivery?
If Yes, please explain. ____

☐ Yes ☐ No Did the patient stay in the hospital for more than two days?
Why? ____

☐ Yes ☐ No Was the patient on mechanical ventilation or oxygen?
Is there anything else that you want to tell us about the patient's birth? ______________________

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Medical information:

Is the patient allergic to any medicines or foods? Please list: ______________________________

____

Who is the primary doctor? ______________________________

What prescription medicines is the patient currently taking: ______________________________

Please list other doctors (specialists) that treat the patient: ______________________________

____

What special medical conditions does the patient have? ______________________________

____

Are there certain precautions that we should know about? ______________________________

____

Please list the patient's hospitalizations and surgeries (with approximate dates): ______________________________

____

☐ Yes ☐ No Are the patient's immunizations current?

☐ Yes ☐ No Does the patient use any special equipment?

Please describe, if yes: ______________________________

____

Developmental information:

☐ Yes ☐ No Do you think the patient sees well?

☐ Yes ☐ No Do you think the patient hears well?

☐ Yes ☐ No Does the patient have frequent ear infections?

☐ Yes ☐ No Has the patient's hearing been tested? When? ___________ Where? ______________________

Results: ______________________________

☐ Yes ☐ No Has the patient's vision been tested? ______________________________

☐ Yes ☐ No Does the patient have problems eating or swallowing?

Explain, if yes: ______________________________

What foods does the patient currently eat? ☐ Breast milk ☐ Bottle ☐ Jar baby food ☐ Finger foods ☐ Table foods

☐ Yes ☐ No Are there foods that the patient refuses to eat?

List: ______________________________

☐ Yes ☐ No Is the patient talkative?

Is the patient's talking understood by:

Parents? ☐ Yes ☐ No Peers? ☐ Yes ☐ No

Siblings? ☐ Yes ☐ No Strangers? ☐ Yes ☐ No

☐ Yes ☐ No Can the patient use his hands and arms well?

Explain, if no: ______________________________

List ages for the following:

Rolled: ______________________ Said first words: ______________________

Sat alone: ______________________ Put two words together: ______________________

Crawled: ______________________ Walked alone: ______________________

Please list any problems that you have noticed in motor or developmental activities: ______________________________

____

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Patient interaction skills:

☐ Yes ☐ No Plays well with others?
☐ Yes ☐ No Has aggressive behavior?
☐ Yes ☐ No Has trouble paying attention?
☐ Yes ☐ No Has difficulty changing from one activity to another?
☐ Yes ☐ No Repeats an activity over and over?
☐ Yes ☐ No Follows directions well?
☐ Yes ☐ No Do you use any specific behavior management techniques at home?

Please explain, if yes: ____

____

☐ Yes ☐ No Is the patient in school?

If yes, please check: ☐ Daycare ☐ Preschool ☐ Elementary School ☐ Middle/Jr. High ☐ High School

If yes, please answer the following three questions:

☐ Yes ☐ No Does the patient have trouble with reading or spelling?
☐ Yes ☐ No Does the patient have problems with handwriting?
☐ Yes ☐ No Is the patient receiving special education services?

Please explain/describe: ____

____

Other therapies:

☐ Yes ☐ No Is the patient currently receiving therapy services?

If yes, what kind of therapy and where?____

____

☐ Yes ☐ No Has the patient received therapy in the past? ______________________

If yes, what kind of therapy and where?____

____

When was the last therapy visit? ____

Thank you for your information.