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	Cook Children's South Rehab Clinic	Cook Children's Child Study Center	Cook Children's Mansfield Rehab	Cook Children's Northeast Rehab
682-885-7660	682-885-4063	682-885-2190	682-885-2200	817-347-2955

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? _____

Along with your child's physical health, we would like to know about your child's mental health.

☐ Yes ☐ No Are there any family issues that might impact your child's care? If so, please share.

_____

☐ Yes ☐ No Have you seen any changes in your child's moods or behavior? If so, please share.

_____

Thank you for your information.

Cook Children's