6830-18

2-Hole 1/4 2 3/4 c-to-c

3-Hole 1/4 4 1/4 c-to-c

Name _____

Date of birth _____

MRN# _____

Account/HAR# _____

PATIENT IDENTIFICATION

Children's Healthcare of Atlanta

REHABILITATION SERVICES DIVISION PATIENT CASE HISTORY

Please complete the following information and bring this form to your first appointment.

GENERAL INFORMATION

Child's name: _____ Date of birth: _____ Sex: ☐M ☐F

☐Parent(s) ☐Guardian ☐Foster parent(s): _____

Address: _____ City: _____ State: _____

Zip code: _____ County: _____ Home telephone (_____) _____

Parent/Guardian 1 occupation: _____ Work phone (_____) _____ Cell phone (_____) _____

Parent/Guardian 2 occupation: _____ Work phone (_____) _____ Cell phone (_____) _____

E-mail address: _____

Emergency phone (_____) _____ Contact person (and relation to patient): _____

Referring physician: _____ Practice: _____ Phone (_____) _____

Reason for referral: _____ Child's age when problems were first noticed: _____

Pediatrician/Primary care physician: _____

Other physicians your child sees: _____ Phone (_____) _____ Specialty: _____

_____ Phone (_____) _____ Specialty: _____

Diagnosis: _____

Additional diagnosis: _____

PARENT'S/GUARDIAN'S CONCERNS/EXPECTATIONS: (What brings you here today?) _____

_____

FAMILY INFORMATION

What language(s) are spoken in the home? ☐English ☐Spanish ☐Other _____

Caregiver(s) with whom the child currently resides: _____ Marital status of caregivers: ☐Married ☐Separated ☐Divorced ☐Widowed ☐Single

How has your child's problem affected your family? _____

List all people now living in the household, including brothers, sisters, other relatives, foster children, friends, etc.

Name	Relationship to Child	Age	Speech/language, hearing, motor, academic or behavioral problems

EDUCATION/THERAPY INFORMATION

Name of daycare, school or program	Dates attended	Placement/Grade	Regular or special class

Have there been any previous evaluations or therapy for speech, hearing, physical, occupational, learning or behavior problems? _____

_____

6830-18

Name _____

Date of birth _____

MRN# _____

Account/HAR# _____

PATIENT IDENTIFICATION

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REHABILITATION SERVICES DIVISION PATIENT CASE HISTORY

Please complete the following information and bring this form to your first appointment.

HEALTH INFORMATION

Immunization status: ☐Up to date ☐Other status _____ Reason, if not up to date: _____

List any concerns that you have about your child's health: _____

List any limitations or precautions due to medical reasons: _____

Current medications:

Medication	Reason	Medication	Reason

Respiratory status: ☐Tracheostomy ☐Speaking valve type: _____ ☐Oxygen ☐CPAP ☐Other _____

Are there any difficulties with child's: Vision ☐No ☐Yes When tested: _____ Where: _____ Results: _____

Hearing ☐No ☐Yes When tested: _____ Where: _____ Results: _____

List your child's dental problems: _____

Please check any conditions that apply to your child's medical history:

☐Vocal nodules
☐Pneumonia
☐Fevers over 104F
☐Ear infections
☐Ear tubes
☐Asthma
☐Reflux
☐Frequent colds
☐Skin disorder

☐Mumps
☐***Myelomeningocele***
☐Hoarse voice
☐Breathy voice
☐Soft voice
☐Loud voice
☐Bronchitis
☐Cleft lip ☐Cleft palate
☐Balance/equilibrium

☐Ear surgery
☐Meningitis
☐Seizures
☐Craniofacial deformities
☐Scarlet fever
☐Throat surgery
☐Tracheotomy
☐Neurological disorder
☐Musculoskeletal disorder

☐Breathes with mouth open: ☐Day ☐Night
☐Adenoidectomy
☐Head injuries/concussion
☐Heart problems
☐Diabetes
☐Cerebral hemorrhage
☐Bronchopulmonary dysplasia
☐Coughing, choking during drinking/eating
☐Injury to ear(s)

☐Snoring
☐Tonsillectomy
☐Bleeding disorder
☐Encephalitis
☐Anemia
☐Hyperactivity
☐Sinus infection
☐Kidney disorder
☐Other

Please describe any medical problems: _____

Operations/Injuries/Special tests (MRI, EEG, swallow study, etc.)	Date(s)	Location(s)

List any special equipment that your child has (i.e. wheelchair, communication board): _____

List any allergies to ☐Foods: _____ ☐***Non-citrus fruits:*** _____

List any allergies to ☐Medications: _____ ☐Molds ☐Pollen ☐Dust ☐Pets ☐***Latex / rubber***

PREGNANCY AND BIRTH HISTORY

Did mother have ☐Accidents ☐High blood pressure ☐Other health problems? If so, describe: _____

List medications taken during pregnancy: _____

Were alcohol, drugs or tobacco used during pregnancy? If so, please describe: _____

Was child born ☐Early ☐Late If so, by how many weeks? _____ Was delivery breech? _____ By C-section? _____ Forceps used? _____

Describe any unusual problems during the birth process: _____

Birth weight: _____ Did infant require oxygen? _____ If yes, how long? _____

Was your baby in the Neonatal Intensive Care Unit? ☐No ☐Yes How long? _____

Was baby jaundiced (yellow) at birth? ☐No ☐Yes Did your baby require a feeding tube ? ☐No ☐Yes Type: _____

Describe any problems noted after birth: _____

_____ _____

Printed name of person completing form | Relationship to patient

_____ _____ _____

Signature of person completing form | Date | Time