



6830-18

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



Children's Healthcare of Atlanta

REHABILITATION SERVICES DIVISION PATIENT CASE HISTORY

Please complete the following information and return before your appointment

PATIENT IDENTIFICATION

GENERAL INFORMATION

Child's name: _____ Birthdate: _____ SEX: M F

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

Address: _____ City: _____ State: _____

Zip Code: _____ County: _____ Home Telephone () _____

Mother's Occupation: _____ Work Phone () _____ Cell Phone () _____

Father's 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, and other relatives, foster children, friends, etc.

<u>Name</u>	<u>Relationship to Child</u>	<u>Age</u>	<u>Speech/ language, hearing, motor, academic, or behavioral problems</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EDUCATION/ THERAPY INFORMATION

<u>Name of Daycare, School or Program</u>	<u>Dates Attended</u>	<u>Placement/Grade</u>	<u>Regular or Special Class</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

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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:

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> Vocal Nodules | <input type="checkbox"/> Mumps | <input type="checkbox"/> Ear Surgery | <input type="checkbox"/> Breathes with mouth open: <input type="checkbox"/> day <input type="checkbox"/> night | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Myelomeningocele | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Fevers over 104 | <input type="checkbox"/> Hoarse Voice | <input type="checkbox"/> Seizures | <input type="checkbox"/> Head Injuries/ Concussion | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Breathly Voice | <input type="checkbox"/> Craniofacial Deformities | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Encephalitis |
| <input type="checkbox"/> Ear Tubes | <input type="checkbox"/> Soft Voice | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Loud Voice | <input type="checkbox"/> Throat surgery | <input type="checkbox"/> Cerebral Hemorrhage | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Tracheotomy | <input type="checkbox"/> Bronchopulmonary dysplasia | <input type="checkbox"/> Sinus infection |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Cleft Lip <input type="checkbox"/> Cleft Palate | <input type="checkbox"/> Neurological disorder | <input type="checkbox"/> Coughing, choking during drinking/ eating | <input type="checkbox"/> Kidney disorder |
| <input type="checkbox"/> Skin disorder | <input type="checkbox"/> Balance/ equilibrium | <input type="checkbox"/> Musculoskeletal disorder | <input type="checkbox"/> Injury to ear(s) | <input type="checkbox"/> 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 _____

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