

**Pediatric Medical History Form**

Name of Child		Name of Parent/Legal Guardian:		SSN#
Address:		City:	State	Zip Code
Insurance Cardholder (if different)		Relationship to cardholder		Phone:
Address:		City:	State	Zip Code
Date of Birth	Age	Length of pregnancy	Sex <input type="checkbox"/> M <input type="checkbox"/> F	APGAR score at birth
Onset of Diagnosis	Referring Physician	Age of Siblings	Grade level	School Attending
If premature list cause if known:				
Note any complications at birth:				
Post Birth Status (oxygen, heart monitor)				
What equipment is used at home:				

Please check if your child has a history of any of the following

- |  |   |
|--|---|
| <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Heart Problems                  | <input type="checkbox"/> Muscular disease     |
| <input type="checkbox"/> Circulation Problems            | <input type="checkbox"/> Lung Disease         |
| <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Kidney Disease       |
| <input type="checkbox"/> Nervous System Disease          | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Cardiac Pacemaker               | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> Metal implants (rods, pins etc) | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Developmental Delay             | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Cerebral palsy                  | <input type="checkbox"/> Allergies            |
| <input type="checkbox"/> Autism                          | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Serious Accident                | <input type="checkbox"/> Mental illness       |
| <input type="checkbox"/> Bone Fracture                   | <input type="checkbox"/> Other: _____         |

For Therapist Use Only

Do you feel your child has feeding difficulties?  Yes  No

During the past month has your child been more upset or distressed than normal?  Yes  No

During the past month has your child been less active or playful?  Yes  No

Are your child's immunizations up to date?  Yes  No

Please list any surgeries or hospitalizations your child has had (include dates if known): \_\_\_\_\_

\_\_\_\_\_

Please list any prescription or non prescription medications you child is taking \_\_\_\_\_

\_\_\_\_\_

Does your child have an established IEP from School?  yes  No

Is your child having difficulty in any of the following areas (please check all that apply)

- |                                       |                                     |                                   |
|---------------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Feeding      | <input type="checkbox"/> Swallowing | <input type="checkbox"/> Talking  |
| <input type="checkbox"/> Rolling over | <input type="checkbox"/> Sitting up | <input type="checkbox"/> Sitting  |
| <input type="checkbox"/> Crawling     | <input type="checkbox"/> Kneeling   | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Balancing    | <input type="checkbox"/> Walking    | <input type="checkbox"/> Running  |
| <input type="checkbox"/> Other: _____ |                                     |                                   |

I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about my child by Jaworski Physical Therapy, Inc. for the purpose of treatment, obtaining payment for treatment and as necessary in order to carry out any healthcare operations that are permitted to the regulations. I am aware that The Practice maintains a "Privacy Notice" which sets forth the types of uses and disclosures that The Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which The Practice will make such use. By signing this Consent, I understand and acknowledge that I have reviewed the "Privacy Notice" which is attached before signing this Consent.

**General:** I hereby assign all medical benefits to include Major Medical, Medicare, Private Insurance and other sponsored programs and health plans and I authorize payment of medical benefits to Jaworski Physical Therapy, Inc. I understand that I am financially responsible for all charges whether or not paid to by said insurance and I hereby authorize said assignee to release all information necessary to secure payment of said payment benefits. The assignment will remain in effect until revoked by me in writing.

**Permission to take Photograph:** I hereby consent \_\_\_ or deny \_\_\_ Jaworski Physical Therapy, Inc. to take a photograph of my child only for the purpose to use in his/her medical chart and will not be disclosed for any other reason without additional permission from me.

\_\_\_\_\_  
Parent/Guardian signature if Minor

\_\_\_\_\_  
Date