Kessler
REHABILITATION CENTER
Select Medical

Outpatient Pediatric Medical History

Patient Name: ______________________ **Preferred Language to discuss healthcare:** ______________________

Parent/Guardian: ______________________ **Telephone #:** ______________________

Pediatrician: ______________________ **Telephone #:** ______________________

Religious/Cultural Needs: ______________________

Special Learning Needs: ______________________

Why is the child here? ______________________

Do you feel the child is in pain? ☐ no ☐ yes location: ______________________

Has the child seen any of the following?

Medical Doctor	☐	Physical Therapist	☐
Psychiatrist/Psychologist	☐	Occupational Therapist	☐
Orthopedist	☐	Speech Therapist	☐
Optometrist/Opthamologist	☐	Neurologist	☐
Osteopath	☐	Chiropractor	☐
Early Intervention Services	☐	School Based Related Services	☐

Has the child EVER been diagnosed with any of the following?

Yes	No		Yes	No	
☐	☐	Cancer	☐	☐	Stroke
☐	☐	Heart Problems	☐	☐	Kidney Disease
☐	☐	High Blood Pressure	☐	☐	Anemia
☐	☐	Asthma/Breathing Problems	☐	☐	Epilepsy
☐	☐	Thyroid Problems	☐	☐	Seizures
☐	☐	Diabetes	☐	☐	Cerebral Palsy
☐	☐	Arthrtitis	☐	☐	Muscular Dystrophy
☐	☐	Depression	☐	☐	Spina bifida/myelomeningocele
☐	☐	Hepatitis	☐	☐	ADD/ADHD
☐	☐	Tuberculosis	☐	☐	Autism/PDD
☐	☐	Fracture	☐	☐	History of Torticollis
		Location: ______________	☐	☐	Other: ______________

Please list any surgeries or hospitalizations: ______________________

______________________ ☐ none

Please list any medications (precription/over the counter): ______________________

______________________ ☐ none

Diagnostic Imaging (x-rays, ultrasound, MRI, bone scans, etc.): ______________________

______________________ ☐ none

Allergies: ______________________ ☐ none

Maternal/Birth History (if < 5 years old): ☐ Child > 5 years old

Medical problems/complications during pregnancy:

☐ No ☐ Yes Please specify: ______________________________

Delivery by: ☐ Vaginal ☐ Caesarean

Full term pregnancy: Yes ☐

No ☐ ________ weeks

Developmental History: Please check if your child had delays or are you concerned with the following developmental skills

Roll stomach to back ________ Sit without assistance ________

Roll back to stomach ________ Pull to stand ________

Crawl (on belly) ________ Cruise ________

Creep (on hands and knees) ________ Walk ________

Toe walking ________

Fine Motor Difficulties: ______________________________

(i.e. holding a crayon/pen/pencil, self feeding, etc.)

Oral Motor Difficulties: ______________________________

(i.e. swallowing, excessive drooling, feeding issues, etc.)

Speech difficulties: ______________________________

Sleeping Concerns: ______________________________

Immunizations: ☐ Current for age

☐ Child has not received immunizations

Parent/Patient Areas of Concern:

1. ______________________________
2. ______________________________
3. ______________________________

Rehabilitation Expectations: ______________________________

Patient Signature: ______________________________ Date: ____________

(Parent or guardian if under 18)

Clinician Signature: ______________________________ Date: ___________ Time: ____________

Clinician Signature: ______________________________ Date: ___________ Time: ____________

Clinician Signature: ______________________________ Date: ___________ Time: ____________