

Welcome to our office and thank you for allowing us to help you!

Medical History Questionnaire – Pediatric

If you are currently receiving Home Health Services please see the front desk immediately.

Patient Information	Acknowledgement and Consent for Oral Disclosure of Protected Health Information																																										
<p>Patient's Name _____ Parent/Guardian Name _____ Address _____ City _____ State _____ Zip Code _____ Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____ Email Address _____ In case of emergency contact: Name/Relationship _____ Phone: (____) _____ General: Male Female DOB ____/____/____ Age _____ Height _____ Weight _____ Race: Caucasian African American Hispanic Asian Other Is your child receiving Home Health Services? Yes No If yes, agency? _____ Who lives in your child's home? _____ How many people live in the home? _____ Please list ages of those living in the home: _____ Have there been any recent changes in your household that may be affecting your family? Yes No If yes, explain: _____ What are your child's normal sleeping hours? Does your child take naps? Yes No If yes, how long? _____ Does your child require special positioning? Yes No If yes, explain: _____</p>	<p>_____ This notice applies to treatment you / your child may receive at Shands Rehab Center for Kids at Magnolia Parke.</p> <p>_____ We understand your / your child's medical information is personal and we are committed to protecting your / your child's medical information. Our providers often discuss your / your child's rehabilitation care with you while receiving therapy services at Shands Rehab Center for Kids.</p> <p>_____ At times, even though reasonable precautions are instituted, other patients and / or health care providers may overhear our discussions.</p> <p>_____ By signing below, I acknowledge that I / or my child will be treated in a joint treatment setting. I understand that if at any time I wish to discontinue treatment in this setting or become uncomfortable with this communication, I will immediately inform my / my child's health care provider.</p> <p><i>I have read and initialed the above policies and agree to work with Shands Rehab Center for Kids to meet the rehab needs of my child.</i></p> <p>_____</p> <p style="text-align: center;">Signature _____ Date _____</p>																																										
Past Medical History	Social History / School Status																																										
<p style="text-align: center;">Check the box next to any illness that applies to YOUR CHILD</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td>Dizziness</td> <td>Blurred Vision</td> <td>Numbness</td> </tr> <tr> <td>Weakness/Fatigue</td> <td>Tingling</td> <td>Seizures</td> </tr> <tr> <td>Back Pain</td> <td>Unsteady Walk</td> <td>Falls</td> </tr> <tr> <td>Heart Disease</td> <td>Asthma</td> <td>Irregular Heartbeat</td> </tr> <tr> <td>High Blood Pressure</td> <td>Heart Murmur</td> <td>Heart Failure</td> </tr> <tr> <td>Scabies</td> <td>Diabetes</td> <td>Tuberculosis</td> </tr> <tr> <td>Hepatitis</td> <td>Cancer (any type)</td> <td>Bone Marrow Trnplt.</td> </tr> <tr> <td>Arthritis</td> <td>Difficulty Speaking</td> <td>Difficulty Reading</td> </tr> <tr> <td>Difficulty Writing</td> <td>Difficulty Feeding</td> <td>Difficulty Chewing</td> </tr> <tr> <td>Difficulty Swallowing</td> <td>Stroke</td> <td>Easy Bruising</td> </tr> <tr> <td>Blood Clots</td> <td>Difficulty Breathing</td> <td>Pneumonia</td> </tr> <tr> <td>Nausea</td> <td>Diarrhea/Constipation</td> <td>Difficulty Urinating</td> </tr> <tr> <td>Hernia</td> <td>Rash/Dry Skin</td> <td>Open Sores</td> </tr> <tr> <td>Impetigo</td> <td>Lice</td> <td>Trnplt. Candidate</td> </tr> </table>	Dizziness	Blurred Vision	Numbness	Weakness/Fatigue	Tingling	Seizures	Back Pain	Unsteady Walk	Falls	Heart Disease	Asthma	Irregular Heartbeat	High Blood Pressure	Heart Murmur	Heart Failure	Scabies	Diabetes	Tuberculosis	Hepatitis	Cancer (any type)	Bone Marrow Trnplt.	Arthritis	Difficulty Speaking	Difficulty Reading	Difficulty Writing	Difficulty Feeding	Difficulty Chewing	Difficulty Swallowing	Stroke	Easy Bruising	Blood Clots	Difficulty Breathing	Pneumonia	Nausea	Diarrhea/Constipation	Difficulty Urinating	Hernia	Rash/Dry Skin	Open Sores	Impetigo	Lice	Trnplt. Candidate	<p>Parents: Single Married Divorced Widowed School Status: Daycare Pre-K Elementary Middle High School Other _____ School Name _____</p>
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If printed electronically, all pages must be stapled.

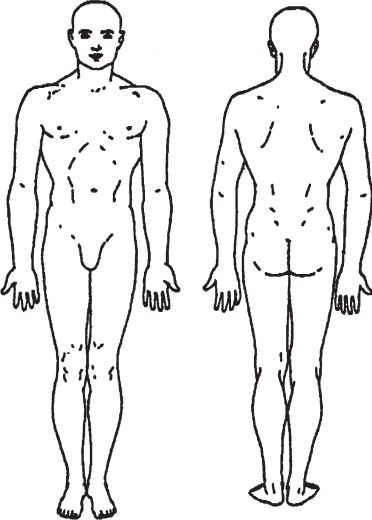
at Magnolia Parke
 4740 NW 39th Place, Suite D Gainesville, FL 32606

3/21/11

Patient Name:

Patient MR #:

Patient Date of Birth:

Special Needs	Pain Assessment / Function / Goals																								
<p>Do you have any special needs to be considered prior to or during treatment (<i>please check all that apply</i>)?</p> <p>Language Cultural Cognitive Glasses/Hearing Physical Religious Emotional Reading/Writing Financial Other _____</p> <p>Are you or your family interested in learning about your special need(s)? Yes No</p> <p>List any assistive devices, adaptive equipment, braces, etc. currently used by your child:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>What services does your child currently receive? <i>Please check all that apply:</i></p> <p>Occupational Therapy Physical Therapy Speech Therapy Special Education Medical Transport Public Transport Orthotics Home Nurse Aide Tutoring Other _____</p>	<p>Past level of function BEFORE this problem began, your child's normal activities were: Normal and unrestricted Minimally restricted Moderately restricted Severely restricted Only heavy activities restricted</p> <p>Present level of function NOW with your child's current condition, normal activities are: Normal and unrestricted Minimally restricted Moderately restricted Severely restricted Only heavy activities restricted</p> <p>Is your child currently experiencing any pain? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the following information:</p> <p>Your child's current pain: Indicate on the diagram below the location and nature of your child's CURRENT pain according to the following symbols:</p> <div style="display: flex; align-items: center;"> <div style="flex: 1;"> <p>(XXX = dull/aching pain; ^^ = sharp pain; +++ = pins and needles; === = numbness)</p> <p>(DO NOT indicate areas of pain which are not related to your child's present problem.)</p> </div> <div style="flex: 1; text-align: center;">  </div> </div> <p>PAIN RATING on a scale of 0 - 10 (0 = no pain; 10 = worst imaginable): <i>Please check number that applies.</i></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 80%;">How would you rate the INTENSITY of your child's pain?</td> <td style="width: 20%; text-align: right;">Intensity is:</td> </tr> <tr> <td>Now 0 1 2 3 4 5 6 7 8 9 10</td> <td style="text-align: right;">Increasing</td> </tr> <tr> <td>Worst Day 0 1 2 3 4 5 6 7 8 9 10</td> <td style="text-align: right;">Decreasing</td> </tr> <tr> <td>Best Day 0 1 2 3 4 5 6 7 8 9 10</td> <td style="text-align: right;">Unchanged</td> </tr> </table> <table style="width: 100%; border: none;"> <tr> <td style="width: 80%;">How STRESSFUL is the pain your child is feeling?</td> <td style="width: 20%; text-align: right;">Distress is:</td> </tr> <tr> <td>Now 0 1 2 3 4 5 6 7 8 9 10</td> <td style="text-align: right;">Increasing</td> </tr> <tr> <td>Worst Day 0 1 2 3 4 5 6 7 8 9 10</td> <td style="text-align: right;">Decreasing</td> </tr> <tr> <td>Best Day 0 1 2 3 4 5 6 7 8 9 10</td> <td style="text-align: right;">Unchanged</td> </tr> </table> <p>What activities make your child's pain WORSE? _____</p> <p>What activities make your child's pain BETTER? _____</p> <p>When are your child's problems most severe? Morning Afternoon Evening Consistent all day</p> <p>Your goals for your child's treatment are: _____</p> <p>_____</p> <p>_____</p>	How would you rate the INTENSITY of your child's pain?	Intensity is:	Now 0 1 2 3 4 5 6 7 8 9 10	Increasing	Worst Day 0 1 2 3 4 5 6 7 8 9 10	Decreasing	Best Day 0 1 2 3 4 5 6 7 8 9 10	Unchanged	How STRESSFUL is the pain your child is feeling?	Distress is:	Now 0 1 2 3 4 5 6 7 8 9 10	Increasing	Worst Day 0 1 2 3 4 5 6 7 8 9 10	Decreasing	Best Day 0 1 2 3 4 5 6 7 8 9 10	Unchanged								
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Immunizations and Hearing / Vision Tests																									
<p>Most recent date of vision / hearing test _____</p> <p>Has your child been recently exposed to any of the following? <i>Please check all that apply:</i></p> <p>Measles Chicken Pox Other Contagious Disease</p>																									
Previous Surgeries																									
<p>Check the box next to any surgical procedure(s) your child has had:</p> <p>Tonsils Heart Ovaries Stomach Appendix Uterus Prostate Colon Thyroid Kidney Other Surgeries _____ Extremity Surgeries _____</p>																									
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<p>Does your child have any allergies to: Penicillin Sulfa Latex Other _____</p>																									
Medications																									
<p>Please elaborate about any medications YOUR child is currently taking:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Medication Name</th> <th style="width: 15%;">Date Started</th> <th style="width: 25%;">Medication Name</th> <th style="width: 15%;">Date Started</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Medication Name	Date Started	Medication Name	Date Started																					<p>_____</p> <p>_____</p> <p>_____</p>
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Shands
RehabCenter
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at Magnolia Parke
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