

Name: Appt Date: Appt Time: OT__PT__ST__

WEST TEXAS REHABILITATION CENTER Pediatric Medical/Social History Form

Abilene

San Angelo

Ozona

Chart #:

Please fill each of the following blocks with the appropriate information.

Child's Name:		DOB:	Today's Date:																																
1. When was the last time the child was seen by a doctor?																																			
2. What is the child's primary problem/concern that brings the child to West Texas Rehab?																																			
3. How long has this problem been noticed?																																			
4. How did this problem start? <input type="checkbox"/> Result of specific injury <input type="checkbox"/> Gradually <input type="checkbox"/> Other (please explain)																																			
5. Please indicate agencies below that are providing services for the child for health problems? <input type="checkbox"/> ECI <input type="checkbox"/> School District/Co-op <input type="checkbox"/> Private Therapist <input type="checkbox"/> Other (explain)																																			
6. What is the primary goal for this child in therapy? What is the main area in need of improvement?																																			
7. Has this child been treated at West Texas Rehab for anything before? <input type="checkbox"/> Yes (explain below) <input type="checkbox"/> No If yes, when and for what?																																			
8. Has this child been in the hospital? <input type="checkbox"/> Yes (please explain below) <input type="checkbox"/> No																																			
Hospital	Dates	Reason																																	
9. Below, please list the child's medications, which doctor is prescribing and that doctor's phone number. <input type="checkbox"/> No Medications Currently <input type="checkbox"/> See Attached List <input type="checkbox"/> I do not remember and will bring a list with me next time.																																			
Medication	Prescribing Physician	Physician's Phone Number																																	
10. Is this child allergic to any medications? <input type="checkbox"/> Yes (please list them below) <input type="checkbox"/> No																																			
<p style="text-align:center;">For the following conditions, make a mark under the "P" if the child had this condition in the PAST or a mark under the "C" if the child CURRENTLY has the condition or the results of the condition.</p> <table style="width:100%; border:none;"> <tr> <td style="width:25%;">P C</td> <td style="width:25%;">P C</td> <td style="width:25%;">P C</td> <td style="width:25%;">P C</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> <input type="checkbox"/> Hearing Problems</td> <td><input type="checkbox"/> <input type="checkbox"/> Sensory Integration Disorder</td> <td><input type="checkbox"/> <input type="checkbox"/> Prematurity</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Lupus</td> <td><input type="checkbox"/> <input type="checkbox"/> Vision Problems</td> <td><input type="checkbox"/> <input type="checkbox"/> Traumatic Brain Injury</td> <td><input type="checkbox"/> <input type="checkbox"/> Other (explain)</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> <input type="checkbox"/> Chronic Bronchitis</td> <td><input type="checkbox"/> <input type="checkbox"/> Learning Disability</td> <td></td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Heart Disease</td> <td><input type="checkbox"/> <input type="checkbox"/> Bone Fracture</td> <td><input type="checkbox"/> <input type="checkbox"/> Muscular Disease</td> <td></td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Paralysis</td> <td><input type="checkbox"/> <input type="checkbox"/> Chronic Pain</td> <td><input type="checkbox"/> <input type="checkbox"/> Developmental Delay</td> <td></td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Stroke</td> <td><input type="checkbox"/> <input type="checkbox"/> Seizure Disorder</td> <td><input type="checkbox"/> <input type="checkbox"/> Orthopedic Problems</td> <td></td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> ADD/ADHD</td> <td><input type="checkbox"/> <input type="checkbox"/> Ear Infection</td> <td><input type="checkbox"/> <input type="checkbox"/> Gastroesophageal Reflux (GERD)</td> <td></td> </tr> </table>				P C	P C	P C	P C	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Hearing Problems	<input type="checkbox"/> <input type="checkbox"/> Sensory Integration Disorder	<input type="checkbox"/> <input type="checkbox"/> Prematurity	<input type="checkbox"/> <input type="checkbox"/> Lupus	<input type="checkbox"/> <input type="checkbox"/> Vision Problems	<input type="checkbox"/> <input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> <input type="checkbox"/> Other (explain)	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> <input type="checkbox"/> Learning Disability		<input type="checkbox"/> <input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Bone Fracture	<input type="checkbox"/> <input type="checkbox"/> Muscular Disease		<input type="checkbox"/> <input type="checkbox"/> Paralysis	<input type="checkbox"/> <input type="checkbox"/> Chronic Pain	<input type="checkbox"/> <input type="checkbox"/> Developmental Delay		<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> <input type="checkbox"/> Orthopedic Problems		<input type="checkbox"/> <input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> <input type="checkbox"/> Ear Infection	<input type="checkbox"/> <input type="checkbox"/> Gastroesophageal Reflux (GERD)	
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Where does the child spend most of his/her day? <input type="checkbox"/> Home <input type="checkbox"/> Day Care <input type="checkbox"/> School <input type="checkbox"/> Other (please explain)		Which of the following financial resources does the child's family have at this time? <input type="checkbox"/> Employment <input type="checkbox"/> CHIP <input type="checkbox"/> Medicaid <input type="checkbox"/> CSHCN (CICD) <input type="checkbox"/> Insurance <input type="checkbox"/> Supplemental Security Income (SSI) <input type="checkbox"/> Pension <input type="checkbox"/> No Income <input type="checkbox"/> Other (please explain)																																	

