"I CAN" Pediatric Therapies, LLC

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Patient History Information

Patient Information:

Name: _____ Date of Birth: _____

Primary Care Physician:_____ Name of Practice: _____

Reason for Referral: _____

How did you hear about I CAN Pediatric Therapies: _____

Is your child enrolled in preschool or school services: Y or N. If yes, where: _____

Is your child currently receiving therapy or special services? Y or N. If yes, when, where, and what type? _____

_____

(if you consent, please send I CAN Pediatric Therapies copies of therapy evaluations, IEP documentation, and any relevant reports.)

Birth History:

Did the Mother experience and infections/illnesses during pregnancy? Y or N If yes, please describe:

_____

Take any medications: _____

Experience any complication during delivery/labor process? Y or N If yes, please describe: _____

_____

Full Term or Premature? (Circle one) Number of Weeks: _____

Weight at Birth: _____ APGAR Score (if known) at 1min_____ at 5mins_____

Breech (Feet First): Y or N Forceps for delivery: Y or N Hospitalization Length: _____

Birth Injuries? Y or N. If Yes, please describe: _____

_____

Developmental Milestones:

Please indicate your child's age when they first began these skills and also please comment on anything unusual you observed:

Rolling over	
Comes to sit alone	
Drinks from a cup	
Says words	
Chews solid food	
Crawls on all fours	Was crawling phase brief: Y or N
Walks	
Says sentences	
Rides tricycle	
Rides bicycle	
Goes up and down steps	
Finger fed	
Used utensils to feed self	
Dresses self	
Manipulates buttons/zippers	
Tied shoes	

Medical History:

Please Check Yes or No and Describe:

Illness:	Yes	No	Description or at what age:	Illness:	Yes	No	Description or at what age:
Adenoidenectomy				Hospitalization			
Allergies				Jaundice			
Anoxia				Measles			
Asthma				Meningitis			
Blood Disease				Mouth Breather			
Chicken Pox				Mumps			
Cyanosis				Muscle Disorder			
Feeding Difficulties				Nerve Disorder			
Colds/Influenza				PE Tubes			
Croup				Plagiocephaly			
Dental Problems				Pneumonia			

Diphtheria				Rheumatic Fever			
Drooling				Seizures			
Ear Infections				Surgery			
Encephalitis				Tonsillectomy			
Head Injuries				Torticollis			
Hearing Impairment				VisionImpairmen			
High Fevers				Other			

Please explain further any checked above or it a condition is not listed that you feel is important please describe:

Describe any major accidents, hospitalizations, or any medical precautions (Latex or food allergies):

_____

_____

Does your child have any medical diagnoses (ADHD, Autism, Dyslexia, Hearing/Vision Impairment, etc)?

If yes at what age was he or she diagnosed? _____

_____

_____

If your child taking any medications? If yes, please list the dosage, frequency and the condition that is

Is being treated. _____

Self-Care:

Please describe the level of assistance that you provide with the following self-care activities with 0 being the "least" (the child is independent) to 5 being the "most".

Self-Care Activity	Level of Assistance	Self-Care Activity	Level of Assistance
Tooth Brushing		Sits for Meals	
Hair Washing		Keeps track of own belongings	
Bathing		Organizes homework/toys	
Dressing themselves		Transitions between tasks and activities	
Haircuts		Toileting Skills	
Buttons on shirts		Buttons on pants	
Manipulates zippers on jackets		Other:	

Self Regulation/Awareness/Behavior/Social: Please write Yes or No and explain as needed.

Attends to toys	
Attends to school	
Explores objects and environments dependently	
Initiates new activities	
Plays appropriately with toys	
Able to perform sequential tasks	
Follows directions	
Plays on playground equipments (slides, ms, monkey bars, etc)	
Enjoys swings	
Enjoys rough house play	
Takes risks	
Seems aware of safety concerns	
Afraid of heights	
Compliant	
Easily Frustrated or gives up easily	
Displays aggression towards self/others	
Cries Easily	
Appears to be impulsive	
Difficult to discipline	
Makes and sustains eye contact	
Interacts well with others	
Shares toys and takes turns	

Parental Concerns:

What have you been told by a doctor, teacher, and or others about your child's abilities and needs?

_____

_____

_____

What do you see as your child's strengths? _____

_____

_____

_____

What are your concerns about your child? _____

_____

_____

_____

What do you hope your child will gain by being seen at I CAN Pediatric Therapies? _____

_____

_____

_____

Signature: _____ Date: _____