Marianjoy
Rehabilitation Hospital

part of Northwestern Medicine®

Pediatric Health and History Form

Thank you for choosing Marianjoy Rehabilitation Hospital, part of Northwestern Medicine, for your child's rehabilitation needs. The following health and history information must be completed and brought to your child's first outpatient therapy appointment. Should you have any questions, please call 630.909.7150.

Patient name _____Date of birth_____

Parent/guardian name _____

Contact number _____

Birth history

Was your child delivered prematurely, full term or late?

_____

Please describe any significant medical information related to the pregnancy, delivery and early infancy.

_____

_____

Length of pregnancy (weeks) _____

Maternal age at delivery_____

Delivery history

Birth hospital _____

Type of delivery (check all that apply):

Vaginal delivery ☐ Yes ☐ No

C-section ☐ Yes ☐ No

Emergency C-section ☐ Yes ☐ No

Normal, healthy delivery ☐ Yes ☐ No

Were there any complications during delivery? ☐ Yes ☐ No

If yes, please list and explain.

_____

_____

_____

_____

_____

_____

_____

_____

Length of stay in hospital (weeks) _____

Child's birth weight _____lbs.

Child's birth length _____inches

Infant vision assessment ☐ Pass ☐ Fail

Infant hearing assessment ☐ Pass ☐ Fail

Significant complications following birth (check all that apply):

Anemia ☐ Yes ☐ No

Arteriovenous malformation (AVM) ☐ Yes ☐ No

Bronchopulmonary dysplasia (BPD) ☐ Yes ☐ No

Cerebral vascular accident (CVA) ☐ Yes ☐ No

Cleft lip/cleft palate ☐ Yes ☐ No

Cytomegalovirus ☐ Yes ☐ No

Failure to thrive ☐ Yes ☐ No

Intrauterine growth retardation (IUGR) ☐ Yes ☐ No

IVH bleed grade _____(I-IV) ☐ Yes ☐ No

Meconium aspiration ☐ Yes ☐ No

Neonatal hypoxia ☐ Yes ☐ No

PDA ☐ Yes ☐ No

Respiratory complications ☐ Yes ☐ No

If yes, please explain.

_____

_____

_____

_____

_____

Ventilator dependency ☐ Yes ☐ No

VP shunt ☐ Yes ☐ No

Pediatric Health and History Form (continued)

Childhood health history (check all that apply):

Asthma/respiratory	☐ Yes	☐ No
Chronic ear infections	☐ Yes	☐ No
Constipation/urination issues	☐ Yes	☐ No
Reflux	☐ Yes	☐ No
Sleeping difficulties	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Surgical procedures	☐ Yes	☐ No

If yes, please list and explain.

_____

_____

Tube fed ☐ Yes ☐ No

Please list any other interventions.

_____

_____

Current medications and supplements

Medication(s)	Dosage	Prescribing physician

Current precautions and allergies

_____

_____

Specialists

	Name/location	Date last seen
Audiologist		
Cardiologist		
Developmental medicine		
ENT		
Gastroenterologist		
Geneticist		
Ophthalmologist		
Pediatrician		
Physiatrist		
Psychologist/psychiatrist		
Pulmonologist		
Surgeon		
Other		

Pediatric Health and History Form (continued)

Developmental milestones

Please list age child completed each of these milestones:

Held head upright independently _____

Rolled tummy to/from back _____

Sat independently _____

Crawled on belly _____

Crawled on hands and knees _____

Stood independently _____

Began walking independently _____

Began eating baby foods _____

Began eating table foods _____

Stopped bottle feeding _____

Brought hands to face/mouth _____

Clapped hands together _____

Grasped toys _____

Began self-feeding finger foods _____

Smiled _____

Laughed _____

Vocalized sounds _____

Verbalized words _____

Behaviors

How does your child communicate needs?

_____

_____

_____

How does your child communicate with family/peers?

_____

_____

_____

Activities your child enjoys (please list)

_____

_____

_____

_____

_____

Activities your child dislikes (please list)

_____

_____

_____

School information

Is your child in school? ☐ Yes ☐ No

If yes, please provide name of school.

_____

Does your child have a current IEP? ☐ Yes ☐ No

Community

Does your child participate in community programs? ☐ Yes ☐ No

If yes, please list.

_____

_____

_____

Therapy history

Has your child received therapy previously? ☐ Yes ☐ No

If yes, please state what type and where.

_____

Does your child currently receive therapy? ☐ Yes ☐ No

If yes, please state what type and where.

_____

Marianjoy Rehabilitation Hospital,
part of Northwestern Medicine
26W171 Roosevelt Road
Wheaton, Illinois 60187
630.909.8000
TTY for the hearing impaired 630.909.8015

marianjoy.org

19-390/1018/PDF