UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Outpatient Rehabilitative Services at
Physician Pavilion II
Pediatric History and Survey

Name of Child: _____

Date of Birth: _____/_____/_____

Please take a few minutes to complete this health survey for your child. Your responses will give us very valuable information regarding the health and development of your child and will help us to provide better services for you and your child. Thank you.

1. Current Condition(s) Chief Complaint(s)

a) Describe the symptom(s) or problem(s) for which you seek therapy for your child: _____

_____

_____

b) When did the symptom(s) start(date)? _____/_____/_____

c) Has your child ever had the symptom(s) before? ☐ NO ☐ YES

d) Is there a family history of symptom(s)? ☐ NO ☐ YES

What did you do for the symptom(s)? _____

_____

Did the symptom(s) improve? ☐ NO ☐ YES

e) What makes the symptom(s) improve? _____

_____

What makes the symptom(s) worse? _____

_____

What are your goals for your child for therapy? _____

_____

Name of Child: _____

Date of Birth: _____/_____/_____

g) Are you seeking anyone else for the symptom(s)? **Check all that apply:**

- ☐ Acupuncturist
- ☐ Cardiologist
- ☐ Chiropractor
- ☐ Dentist
- ☐ Orthopedist
- ☐ Internist
- ☐ Nurse Practitioner
- ☐ Massage Therapist
- ☐ Neurologist
- ☐ Podiatrist
- ☐ Pediatrician
- ☐ Surgeon
- ☐ Rheumatologist
- ☐ Osteopathic Physician
- ☐ School Physical Therapist
- ☐ School Occupational
- ☐ Therapist
- ☐ School Speech Therapist
- ☐ Primary Care Physician
- ☐ Family Practitioner
- ☐ Audiologist
- ☐ Other:_____

2. Medications

a) Does your child take any prescription medications?

☐ NO ☐ YES: Please list them:_____

_____

b) Does your child take any over the counter (non-prescription) medications? **Check all that apply:**

- ☐ Advil/Ibuprofen
- ☐ Antacids
- ☐ Aspirin
- ☐ Aleve/Naproxen
- ☐ Decongestants
- ☐ Herbal Supplemants
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

3. Allergies

a) Does your child have any known allergies or adverse reactions to any prescription(s) or over the counter medications or food allergies?

☐ NO ☐ YES: Please list them:_____

_____

4. Clinical Tests: Within the past year has your child had any of the following tests?
Check all that apply:

- ☐ Angiogram
- ☐ Arthroscopy
- ☐ Biopsy
- ☐ Blood Tests
- ☐ Bone Scan
- ☐ CT Scan
- ☐ Modified Barium Swallow Test
- ☐ Doppler Ultrasound
- ☐ Echocardiogram
- ☐ EEG (Electrocephalogram)
- ☐ EKG (Electrocardiogram)
- ☐ EMG (Electromyogram)
- ☐ MRI
- ☐ Myelogram
- ☐ NCV (Nerve Conduction Velocity)
- ☐ Pulmonary Function Test
- ☐ Spinal Test
- ☐ Stress Test (e.g. treadmill, bicycle)
- ☐ X-rays
- ☐ Other:_____

Name of Child: _____

Date of Birth: _____/_____/_____

4. Medical History

a) Has your child ever had or been diagnosed with?
Check all that apply:

- ☐ Arthritis
- ☐ Cancer
- ☐ Muscular Dystrophy
- ☐ Repeated Infections
- ☐ Mental Retardation
- ☐ Aspergers
- ☐ Attention Deficit Disorder
- ☐ Lung Problems
- ☐ Learning Disabilities
- ☐ Blood Disorders
- ☐ Circulation Problems
- ☐ ADHD (Attention Deficit Hyperactivity Disorder)
- ☐ Dysgraphia
- ☐ Broken Bones/Fractures
- ☐ Cerebral Palsy
- ☐ Kidney Problems
- ☐ High Blood Pressure
- ☐ Downs Syndrome
- ☐ Seizures/Epilepsy
- ☐ Skin Diseases
- ☐ Stroke
- ☐ Developmental Delay
- ☐ Infections Disease (e.g. Hepatitis, AIDs)
- ☐ Diabetes/High Blood Sugar
- ☐ Speech/Language Impairment
- ☐ Thyroid Problems
- ☐ Head Injury
- ☐ Heart Problems
- ☐ Brachial Plexus Injury
- ☐ Autism
- ☐ PDD (Pervasive Developmental Disorder)
- ☐ Ulcers/Stomach Problems
- ☐ Depression
- ☐ Growth Problems
- ☐ Hypoglycemia/Low Blood Sugar
- ☐ Emotional Disturbance
- ☐ Cleft Palate
- ☐ Other:_____

b) Was your child carried to full term (36-40 weeks gestation)? ☐ NO ☐ YES

If no, how many weeks/months gestation? _____

c) Within the past year has your child had any of the following symptoms?
Check all that apply:

- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Cough
- ☐ Hoarseness
- ☐ Shortness of Breath
- ☐ Dizziness or Blackouts
- ☐ Weakness in Arms & Legs
- ☐ Loss of Balance
- ☐ Difficulty Walking
- ☐ Joint Pain or Swelling
- ☐ Pain at Night
- ☐ Difficulty Sleeping
- ☐ Loss of Appetite
- ☐ Bowel Problems
- ☐ Weight Loss/Gain
- ☐ Urinary Problems
- ☐ Fever/Chills/Sweats
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Difficulty Swallowing
- ☐ Difficulty being understood by others
- ☐ Other: _____
- ☐ Other: _____

d) Has your child ever had surgery?

☐ NO ☐ YES: Please list them and include approximate dates.

_____ Date_____/_____

_____ Date_____/_____

_____ Date_____/_____

Name of Child: _____

Date of Birth: _____/_____/_____

5. General Health Status

a) Please rate your child's health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

b) Has your child had any major life changes in the past year?
(e.g. new baby, death of a loved one, divorce)

☐ NO ☐ YES: Please explain briefly:_____

_____

6. Social/Health Habits

a) Exercise: Does your child play outdoors? ☐ NO ☐ YES

If Yes, how many hours on average per week? _____

How many minutes on average each day? _____

b) Is your child involved in community activities
(e.g. sports teams, recreation programs, dance classes)? ☐ NO ☐ YES

If Yes, how many activities?_____ How many hours each week?_____

c) Does your child have any siblings? If so, what are their ages?_____

d) Primary language spoken?_____

Other languages spoken?_____

7. Social History

a) Cultural/Religious: Are there any customs or religious beliefs that might affect
your child's care? Please explain: _____

_____

b) Education: Does your child struggle academically? ☐ NO ☐ YES

Has he or she ever been referred for I.E.P. or 504 Plan? ☐ NO ☐ YES

Is he or she on an educational I.E.P. or 504 Plan? ☐ NO ☐ YES

If Yes, please bring a copy with you and all pertinent assessments
for your first appointment.

Name of Child: _____

Date of Birth: _____/_____/_____

Please complete the following developmental milestones checklist as it will help us better serve your child's needs.

When your child reached the age of three months did he or she:

Follow moving person with eyes while lying on his/her back?	☐ NO	☐ YES
Lift head and chest while lying on his/her stomach?	☐ NO	☐ YES
Grasp rattle when given to the child?	☐ NO	☐ YES
Make sounds (ah/eh/ugh)?	☐ NO	☐ YES
Cry when hungry or upset?	☐ NO	☐ YES

When your child reached the age of six months did he or she:

Clasp hands?	☐ NO	☐ YES
Reach for and grasp objects?	☐ NO	☐ YES
Follow moving object with eyes without moving head?	☐ NO	☐ YES
Respond to voice by turning head in direction of source?	☐ NO	☐ YES
Laugh out loud?	☐ NO	☐ YES

When your child reached the age of nine months did he or she:

Play with toy actively by moving wrists?	☐ NO	☐ YES
Reach and grasp objects with straight elbow?	☐ NO	☐ YES
Crawl and sit up?	☐ NO	☐ YES
Babble?	☐ NO	☐ YES
Make sounds like da, ba, ma, ga, ka?	☐ NO	☐ YES
Imitate sounds you make?	☐ NO	☐ YES

When your child reached the age of twelve months did he or she:

Take objects out of container?	☐ NO	☐ YES
Clap hands?	☐ NO	☐ YES
Drink from a cup with help?	☐ NO	☐ YES
Stand momentarily?	☐ NO	☐ YES
Walk with one hand held?	☐ NO	☐ YES
Say first word?	☐ NO	☐ YES
Understand short phrases, i.e. "no-no" or "all gone"?	☐ NO	☐ YES

Name of Child: _____

Date of Birth: _____/_____/_____

Milestones checklist continued

When your child reached the age of two years did he or she:

Walk along?	☐ NO	☐ YES
Pick up toys from a standing position?	☐ NO	☐ YES
Mark paper with crayon?	☐ NO	☐ YES
Grasp and hold a small ball?	☐ NO	☐ YES
Turn two to three pages at a time?	☐ NO	☐ YES
Speak in two word sentences?	☐ NO	☐ YES
Follow one step directions, i.e. “point to the_____”?	☐ NO	☐ YES
Name at least five objects?	☐ NO	☐ YES

When your child reached the age of three years did he or she:

Run forward?	☐ NO	☐ YES
Jump in place with both feet together?	☐ NO	☐ YES
Kick ball forward?	☐ NO	☐ YES
String large beads?	☐ NO	☐ YES
Turn pages one by one?	☐ NO	☐ YES
Draw a circle?	☐ NO	☐ YES
Answer simple questions when asked?	☐ NO	☐ YES
Speak in four to five word sentences?	☐ NO	☐ YES
Understand concepts/pronouns: she, her, he, his, soft, hard, etc.?	☐ NO	☐ YES

When your child reached the age of four years did he or she:

Hop on one foot three times?	☐ NO	☐ YES
Bounce and catch a large ball?	☐ NO	☐ YES
Ride a tricycle?	☐ NO	☐ YES
Copy a square?	☐ NO	☐ YES
Recognize most colors?	☐ NO	☐ YES
Tell stories?	☐ NO	☐ YES

When your child reached the age of five years did he or she:

Skip and gallop?	☐ NO	☐ YES
Copy a triangle?	☐ NO	☐ YES
Complete a picture of a stick person?	☐ NO	☐ YES
Cut out basic shapes (e.g. triangle/square) with scissors?	☐ NO	☐ YES
Recite nursery rhymes/songs?	☐ NO	☐ YES
Speak in complete sentences?	☐ NO	☐ YES
Follow multiple directions?	☐ NO	☐ YES
Be clearly understood by most people?	☐ NO	☐ YES

Name of Child: _____

Date of Birth: _____/_____/_____

Please complete the following sensory motor checklist as it pertains to your child. Thank you.

When considering the sense of touch, does your child:

Object to being touched?	☐ NO	☐ YES
Prefer to touch rather than be touched?	☐ NO	☐ YES
Resist wearing certain textures of clothing?	☐ NO	☐ YES
Isolate self from other children?	☐ NO	☐ YES
Frequently bump and push other children?	☐ NO	☐ YES

When considering the sense of hearing, does your child:

Seem overly sensitive to sound?	☐ NO	☐ YES
Miss some sounds?	☐ NO	☐ YES
Seem confused about the direction of sounds?	☐ NO	☐ YES
Make loud noises inappropriately?	☐ NO	☐ YES
Have a diagnosed hearing loss?	☐ NO	☐ YES

When considering the sense of smell, does your child:

Attempt to smell objects other than food?	☐ NO	☐ YES
Discriminate odors?	☐ NO	☐ YES
React defensively to smell?	☐ NO	☐ YES
Ignore noxious odors?	☐ NO	☐ YES

When considering the sense of vision, does your child:

Have a diagnosed vision problem?	☐ NO	☐ YES
Have difficulty following objects with their eyes?	☐ NO	☐ YES
Become excited when confronted with a variety of visual stimuli?	☐ NO	☐ YES
Avoid eye contact?	☐ NO	☐ YES

When considering the sense of taste, does your child:

Act like all foods taste the same?	☐ NO	☐ YES
Explore by tasting?	☐ NO	☐ YES
Dislike foods of a certain texture?	☐ NO	☐ YES
Crave certain foods (salty, sweet, sour)?	☐ NO	☐ YES

Name of Child: _____

Date of Birth: _____/_____/_____

Sensory motor checklist continued

When considering the sense of movement, does your child:

Dislike rough housing?	☐ NO	☐ YES
Seem fearful in space (e.g. going up and down stairs, riding a teeter totter)?	☐ NO	☐ YES
Appear clumsy, often bumping into things or falling down?	☐ NO	☐ YES
Prefer fast moving and/or spinning rides?	☐ NO	☐ YES
Seek out spinning/rocking activities?	☐ NO	☐ YES

When considering muscle tone, does your child:

Have any diagnosed muscle problems (e.g. spasticity, flaccidity, rigidity)?	☐ NO	☐ YES
Frequently grasp objects too tightly?	☐ NO	☐ YES
Have a weak grasp?	☐ NO	☐ YES
Tire easily?	☐ NO	☐ YES
Sit or walk with poor posture?	☐ NO	☐ YES

When considering coordination, does your child:

Manipulate small objects with fingers?	☐ NO	☐ YES
Seem accident prone?	☐ NO	☐ YES
Have difficulty with pencil/crayon activities?	☐ NO	☐ YES
Have difficulty dressing and/or fastening clothes?	☐ NO	☐ YES
Have a consistent hand preference/dominance?	☐ NO	☐ YES
Use two hands together when needed (e.g. playing ball, cutting with scissors)?	☐ NO	☐ YES

Signature of person completing this history:

_____Date:_____/_____/_____

This is the end of the history and survey. Thank you! Your information will allow us to better meet the needs of your child.

Reviewed by:_____Date:_____/_____/_____