Idaho State University

ISU Physical & Occupational Therapy Associates
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Pediatric Patient Profile

Patient Name: ______________________ **DOB:** ______________

School: ______________________ **Grade:** __________ **Age:** __________

Parent/Guardian: ______________________

Emergency Contact: ______________________ **Phone No.:** ______________

Home Phone: ______________________ **Cell Phone:** ______________

Is it ok for us to leave a message regarding your child's treatment at the following #s?

Home: ☐ Yes ☐ No **Cell:** ☐ Yes ☐ No

Reasons for Rehabilitation

Diagnosis/Conditions/Reasons you are seeking rehabilitation services: ______________________

____

____

Your Primary goal for therapy is to be able to? ______________________

____

____

Health History

Birth History: ____

____

Developmental Milestones: (At what age did your child independently achieve)

Sitting Up: ______________ Babbling: ______________ Put Words Together: ______________

Crawl: ______________ Eat Solid Foods: ______________ Understood by Strangers: ______________

Walk: ______________ 1st Word: ______________ Toilet Trained: ______________

Current No. of Words: ______________

How much is your child understood by family? ☐ None ☐ Some ☐ Most ☐ Totally

How much is your child understood by strangers? ☐ None ☐ Some ☐ Most ☐ Totally

Medical Issues:

Does your child now have (or have you had) any of the following conditions? Please check all that apply.

Condition	Y/N	Condition	Y/N	Condition	Y/N
Ear Infections	☐ Y ☐ N	Stress Disorders	☐ Y ☐ N	Stroke	☐ Y ☐ N
Tongue Thrust	☐ Y ☐ N	Developmental Delay	☐ Y ☐ N	Seizures	☐ Y ☐ N
Hoarseness	☐ Y ☐ N	Diabetes	☐ Y ☐ N	Pneumonia	☐ Y ☐ N
Cleft Repair	☐ Y ☐ N	PE/Ear Tubes	☐ Y ☐ N	Asthma/Hay Fever	☐ Y ☐ N
Tonsillectomy	☐ Y ☐ N	Headaches/Migraines	☐ Y ☐ N	Swallowing/Feeding	☐ Y ☐ N
Head Injury	☐ Y ☐ N	Concussion	☐ Y ☐ N	Other: ___________	☐ Y ☐ N

How would you describe your child's general health? ☐ Good ☐ Fair ☐ Poor

If fair/poor, please explain: ____

____

____

List any dietary restrictions (diabetic, food allergies, etc.): ______________________

____

Are there any other health problems that you would like us to know about? ☐ Yes ☐ No

If yes, please explain: ____

____

Does your child use a wheelchair, walker, or other assistive device for mobility? ☐ Yes ☐ No

If yes, identify which type of device: ____

Has your child had any previous surgeries? ☐ Yes ☐ No If yes, please explain below.

	Surgery/Procedure	Month/Year
1.		
2.		
3.		
4.		

Does your child have any allergies? ☐ Yes ☐ No If yes, please list any allergies and the reaction your child experiences to each below (e.g., allergies to medications, latex, foods, products, etc.)

	Allergen	Reaction
1.		
2.		
3.		
4.		
5.		

Medications:

Is your child currently taking any medication? ☐ Yes ☐ No If yes, please list below.

1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Previous Therapies:			
Type of Therapy	**Dates**	**Agency**	**Name of Therapist**
Speech Therapy			
Physical Therapy			
Occupational Therapy			
Psychological/Counseling			
Other Rehab			

Special Needs: (Please check all that apply)

Vision: ☐ No Problems ☐ Glasses/Contact Lenses ☐ Visual Difficulties ☐ Glasses for Reading ☐ Require Enlarged Print

Communication: ☐ No Problems ☐ Difficulty Reading ☐ Difficulty Writing

☐ Communication Needs/Devices/Assist, please specify: ____

____

Hearing: ☐ No Problems ☐ Hearing Aid(s) ☐ Difficulty Hearing

Areas of Concern:

Production of Speech Sounds	☐ Yes	☐ No	Voice	☐ Yes	☐ No
Understanding/Following Directions	☐ Yes	☐ No	Stuttering/Fluency	☐ Yes	☐ No
Understanding Questions	☐ Yes	☐ No	Understanding/Speaking English	☐ Yes	☐ No
Expressing Ideas/Wants/Needs	☐ Yes	☐ No	Pragmatics/Social Language	☐ Yes	☐ No

Below are words to describe your child's personality and behavior. Circle all that apply.

Happy	Aggressive	Depressed	Enthusiastic	Friendly
Warm	Independent	Energetic	Distractible	Jealous
Tense	Prefers to be Alone	Dependent	Affectionate	Relaxed
Critical	Easily Fatigued/Tired	Directive	Can't Sleep	Impatient
Shy	Vigorous	Calm	Irritated	Angry

List description(s) not listed above: ____

Interests/Activities:

How does your child feel about therapy? ____

How does your child feel about unfamiliar people/situations? ____

How does your child transition? ____

Tips that help you with transitions? ____

How does your child typically communicate with you? ____

What are your child's favorite things? ____

What are your child's favorite activities/hobbies? ____

What are your child's favorite motivators? ____

What are your child's least liked things? Avoidance? ____

How does your child react to them? ____

Is your child aware of his/her communication difference? ____

Is your child concerned about his/her communication difference? ____

Is there anything else you would like us to know that would help us to best serve your child's needs?

____

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