.

Patient Name:______________________**Phone: (Day)**_________________**(Evening)**_____________

Diagnosis/Problem___________________**DOB:**___________ **Age:**________ **Male/Female**__________

Patient/Caregiver Name(s):____

Phone: (Day)_____________ (Evening)_______________ (Cell)___________________

Emergency Contact Name:____

Phone: (Day)_____________ (Evening)_______________ (Cell)___________________

Reason for today's visit____

Other physicians involved in child's care____

When did the problem start/When did concerns arise?_____________________________________

Please list any previous or current therapy, training, special services:_________________________

____

Medical History: Please check if you have had problems with any of the following:

Systems:	**Systems (cont.):**	**Neurological:**	**Medical:**	**Medical (cont.):**
☐Asthma/Allergies ☐Food Allergies ☐Latex Allergy ☐Swallowing Problems ☐Retinopathy of Prematurity ☐Visual Problems	☐ Hearing Problems ☐ Chronic Ear Infections ☐ Balance Problems ☐ Back Pain ☐ Fractures ________ ☐ Speech/Language Problems	☐ Autism ☐ Down's Syndrome ☐ Cerebral Palsy ☐ Spina Bifida ☐ Seizures/Epilepsy ☐ Traumatic Brain Injury	☐ Heart Problems ☐ Cancer ☐ Headaches/Migraines ☐ HIV/AIDS ☐ Diabetes ☐ Depression ☐ Tuberculosis	☐Juvenile Arthritis ☐CMV ☐Hepatitis ☐Other, please ☐Specify ________ ________________

Surgeries/Hospitalizations (please list reason & date:)____

____

List current medications and dosages:____

List any allergies (medications, foods, latex, rubber):_____________________________________

List any current medical or adaptive equipment used:______________________________________

Birth History:

Were there any problems with the pregnancy/birth? ☐Yes ☐ No

If yes, please describe:____

____

Prematurity: ☐ Yes ☐ No If yes, please complete the following:

# of weeks early ______; Neonatal Unit: ☐ Y ☐ N ; Ventilator at birth: ☐ Y ☐ N ; Feeding tube at birth: ☐Y ☐ N

(Continued on Back)

Carolinas Rehabilitation
Pediatric Outpatient Intake Form

Patient Name
U/MR # DOB

Physician

Developmental History:

When did your child: roll ________________ sit ______________ walk _____________ talk______________________

Does your child have any problems eating? ____

List any developmental problems/concerns: ____

____

____

____

Preschool/School History:

Current School/daycare:____ Current Grade Level: _____________

Any academic/preacademic problems:____

Please list any special services provided by the school:____

____

Social History:

Who resides in the home with the child?____

Have there been any major life changes that may impact therapy?____

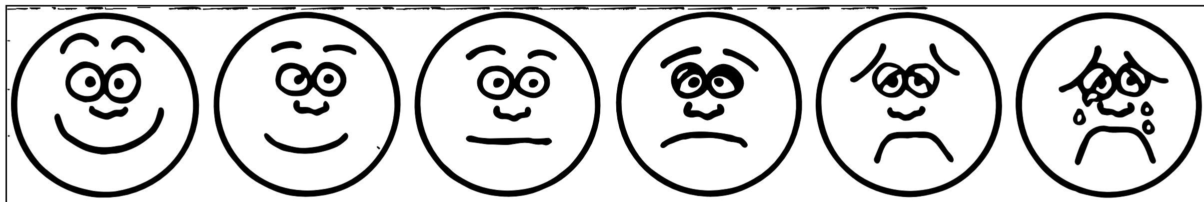
____

____

What are your goals for therapy?____

Pain: (Parent/Guardian- Please have child point to face that best describes their pain)

Wong-Baker Faces Pain Rating Scale



0 1 2 3 4 5

Each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain. **Face 0** is very happy because he doesn't hurt at all. **Face 1** hurts just a little bit. **Face 2** hurts a little more. **Face 3** hurts even more. **Face 4** hurts a whole lot. **Face 5** hurts as much as you can imagine, although you don't have to be crying to feel this bad. Choose the face that best describes how he or she is feeling.

Recommended for persons age 3 years and older.

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This intake form was reviewed by:____

Clinician Signature Date/Time

____