# Pediatric Medical History

## Intake Information

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

- Is the child adopted or in the foster care system? (circle one)
  - Yes
  - No

What concerns would you like to address with therapy?

_____

What are the child's favorite toys or play activities?

_____

**Background Information**

Pregnancy complications/concerns:

_____

Born at _____ weeks

- Method of Birth (circle one):
  - Vaginal
  - C-section

Delivery complications/concerns:

_____

NICU Stay? _____

Complications/concerns following birth:

_____

Home Environment (who does the child live with?):

_____

**Diagnostic Information**

Any diagnoses, suspected diagnoses, or medical conditions?

_____

Allergies? _____

Hearing or vision concerns? _____

Medications: _____

Surgeries or Special Tests:

_____

## Developmental Information

Do you have any concerns about the child's **motor** development?

If yes, what concerns? _____

Gross Motor Milestones (if applicable)

- At what age did your child complete...
  - Rolling? _____
  - Sitting? _____
  - Crawling? _____
  - Walking? _____

Fine Motor Milestones (if applicable)

- Can your child...
  - Stack blocks? _____
  - Pick up small items (beads, cheerios)? _____
  - Concerns with handwriting? _____
  - Other concerns: _____

Do you have concerns with the child's **daily activities**?

- Dressing? _____
- Toileting? _____
- Bathing? _____
- Feeding? _____
- Grooming (hair brushing, brushing teeth, nail trimming)? _____
- Handwriting? _____

Do you have any concerns with **sensory processing or regulation**?

_____

Do you have any concerns with **feeding**?

_____

Do you have any concerns with **speech**?

_____

## Additional Information

Does your child receive therapy services through a school district?

_____

Other applicable information: