



Boulder Community Hospital

DEPARTMENT OF PEDIATRIC REHABILITATION SERVICES CHILD AND FAMILY HISTORY

Child: _____ Male Female Age: _____ DOB: _____

Parents/Guardians: _____

Court Appointed Guardians: _____

Cell phone #: _____ Email address: _____

Would you like to receive communication via e-mail? Yes No

Household Members	Occupation (Optional)	Age	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REASON FOR EVALUATION / VISIT

Referred by: _____

Please list your goals for evaluation/therapy: _____

Please list your child's strengths: _____

Please provide any additional information you feel would be helpful for us to know about your child: _____

MEDICAL HISTORY

Height: _____ % Compared to Peers: _____ Weight: _____ % Compared to Peers: _____

Vision Screening Date: _____ Results: _____

Hearing Screening Date: _____ Results: _____

Dental Screening Date: _____ Results: _____

Primary Care Physician: _____ Phone Number: _____

Current Medical Diagnoses: _____

Current Medications:	Dosage:	Administered for:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Mark all of the following conditions that apply and provide approximate dates.

Condition	Year	Condition	Year
<input type="checkbox"/> Autism Spectrum Disorder	_____	<input type="checkbox"/> Failure to Thrive	_____
<input type="checkbox"/> Meningitis	_____	<input type="checkbox"/> Abuse / Neglect by whom? _____	_____
<input type="checkbox"/> Encephalitis	_____	_____	_____
<input type="checkbox"/> Head Injury	_____	<input type="checkbox"/> Wetting after 3 years of age	_____
<input type="checkbox"/> Seizures _____type	_____	<input type="checkbox"/> Soiling after 3 years of age	_____
<input type="checkbox"/> Allergies _____type	_____	<input type="checkbox"/> Chronic constipation	_____
Food	_____	<input type="checkbox"/> Chronic diarrhea	_____
Environmental	_____	<input type="checkbox"/> Surgery _____ type & dates	_____
Medications	_____	<input type="checkbox"/> Accident / Serious Injury _____type	_____
Latex Sensitivity	_____		
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Ear Infections (How many? _____)	_____	_____	_____
<input type="checkbox"/> Frequent Respiratory Infections	_____		
<input type="checkbox"/> Hospitalization Why? _____	Dates _____		

FAMILY MEDICAL HISTORY – Please list family member’s relationship to child.

- ADHD
- Learning Issues
- Drug Abuse
- Bipolar
- Schizophrenia
- Other _____
- Autism/Aspergers/POD
- Alcoholism

PREGNANCY AND BIRTH HISTORY

Place of Birth: _____ Hospital: _____ Apgar scores _____
Duration of Pregnancy: Full Term Premature – Gestational age: _____ Birth Weight _____
Please list any complications during the pregnancy: for you or your child _____

Complications during /following birth (check all that apply):

- No complications
- Unusually long labor -- length: _____
- Cesarean section
- Severe jaundice
- Postpartum Depression
- Hemorrhaging

Delivery aided by instruments type: _____ Oxygen at birth – How long? _____ Complications for mother
 Other _____
 Require special care after birth – who? _____
 Fetal distress _____ Seizures _____
 Length of Stay for Mother: _____ Length of Stay for Child: _____
 Please provide any additional information for items marked above: _____

THERAPY HISTORY

Has your child received treatment at this facility before? Yes No

Therapist	Dates	Beneficial?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

List other professionals and/or agencies who are or have been involved with your child:

Agency/Therapist	Phone #	Dates	Beneficial?
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide copies of evaluations!

CAREGIVER / SCHOOL INFORMATION

Type of School Your Child Attends: Daycare Preschool School Not applicable

Location: _____ Contact: _____ Grade: _____

School Phone Number and Address: _____

Services Received: Individual Educational Plan through school district ___no ___ yes - Services provided: _____
 Individual Family Service Plan through Imagine! ___no ___ yes - Services provided: _____
 504 Plan ___no ___ yes - Services provided: _____

Teacher comments: _____

Academic skills _____

Relationship with peers _____

Child's impression of school _____

List community classes and activities (e.g., swim class, soccer, etc.) _____

FAMILY HISTORY

Have any of the following events occurred in your family? (Mark all that apply):

Event	Date	Child's reaction to event
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- Move to a new location _____
- Birth of a sibling _____
- Change of school for child _____
- Separation from parent _____
- Serious illness or injury _____
- Death in family _____
- Change in job status _____
- Divorce or separation _____

ADDITIONAL INFORMATION

Please list your child's strengths: _____

Please provide any additional information you feel would be helpful for us to know about your child: _____

FALL RISK

Does your child fall more often than his/her peer group? Y N

Has your child suffered a head injury from a fall within the past year? Y N

(Head injury = loss of consciousness, memory impairment, significant injury requiring a medical attention)

EDUCATIONAL LEARNING STYLE/PREFERENCES

How do you best learn? Verbal Written Visual Demonstration

How does your child best learn? Verbal Written Visual Demonstration

Barriers to your child's learning: None Physical Emotional Cognitive

Person(s) filling out this form: _____ Date: _____

Thank you. If you have any questions, please contact us at (303) 441-0526.