Access Rehab Centers
A Waterbury Hospital & Easterseals Partnership in Physical Rehabilitation

Thank you, for choosing Access Rehab Centers. We kindly request that you fill out all the necessary information for our therapists to complete a comprehensive evaluation of your child. Please mail this packet back prior to the evaluation, if possible, so it can be reviewed.

PEDIATRIC - CASE HISTORY FORM

Child's Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City, State, Zip: _____

Who does the child live with? _____

Mother's Name: _____ Age: _____
Mother's Occupation: _____ Work Phone: _____

Father's Name: _____ Age: _____
Father's Occupation: _____ Work Phone: _____

Referred by: _____ Phone: _____
Address: _____

Pediatrician: _____ Phone: _____
Address: _____

Other Doctors: _____ Phone: _____
Address: _____

Brothers & Sisters (including names and ages): _____
_____
_____
_____

What languages does the child speak?
_____
_____

What is the child's primary language?
_____
_____

What languages are spoken in the home?
_____
_____

What is the primary language spoken in the home?
_____
_____

With whom does the child spend most of his/her time? _____
_____

How does your child usually communicate? (Gestures, single words, short phrases, sentences.)

Why are you bringing your child in for an evaluation? What are the problems that have been noticed? (Does not talk, can not sit still, has a diagnosed condition, etc.)

When was the problem first noticed? By whom?

What do you think caused the problem?

Has the problem changed since it was first noticed?

Is the child aware of the problem? If yes, how does he/she feel about it?

Is your child or was the child involved in a birth-to-three program?

Have any other specialists seen the child? (Physicians, psychologists, special ed teachers?)
Who and when? What were their conclusions/suggestions?

Have any other therapists seen the child? (Speech, occupational or physical therapy) and was it for the same problem?

Does anyone in your family have similar problems to those of the child?

PRENATAL AND BIRTH HISTORY

Mother's general health during pregnancy (illness, accidents, medications, etc.)

Length of pregnancy: _____ Length of Labor: _____
General Condition: _____ Birth Weight: _____
Circle type of delivery: Head first Feet first Breech Caesarian
Were there any unusual conditions that may have affected the pregnancy or birth?

MEDICAL HISTORY

Provide the approximate ages at which the child suffered the following illnesses and conditions:

Allergies	Asthma	Chicken Pox
Colds	Convulsions	Croup
Dizziness	Draining Ear	Ear Infections
Encephalitis	German Measles	Headaches
High Fever	Influenza	Mastoidtis
Measles	Meningitis	Mumps
Pneumonia	Seizures	Sinusitis
Tinnitus	Tonsilitis	Other

Has the child had any surgeries? If yes, what type and when? (ex. Tube placement, tonsillectomy)

Describe any major accidents or hospitalizations.

Is the child taking any medications? Please list name and reason for medication.

Have there been any reactions to medications? If yes, please describe.

Has the child had a hearing test? Results?

DEVELOPMENTAL HISTORY

Provide the approximate age at which the child began to do the following activities:

Crawl	Use Single Words (no, mom, dog)
Sit	Combine Words (me go, daddy shoe)
Stand	Name Simple Objects (dog, car)
Walk	Use Simple Questions (where's doggie?)
Feed Self	Engage in Conversation
Dress Self	Use Toilet

Does the child have any difficulty walking, running, or participating in other activities which require small or large muscle coordination?

Do you feel your child is excessively clumsy?

Are there or have there ever been any feeding problems (problems with sucking, swallowing, drooling, chewing, etc). If yes, please describe.

Describe the child's response to sound (afraid of loud noises, responds to all sounds, inconsistently responds to normal sounds, etc.)

Does your child require assistance with daily activities dressing, showering, use bathroom, feeding, etc? If yes, please describe level of assistance needed.

EDUCATIONAL HISTORY

School: _____ Grade: _____

Teacher: _____

Has the child been diagnosed with any type of learning disability?

How is the child doing academically (or pre-academically)?

Does the child receive special services? If yes, please describe:

How does the child interact with others (shy, aggressive, uncooperative, etc)?

Does the child's teacher have any concerns?

Please list any special education services the child receives.

Is your child enrolled in public, private, parochial, or alternative school?

SENSORY INFORMATION

Does your child tend to fall down or bang into things a lot?

Does your child have a bad reaction to:

Loud noises	Yes ❑	No ❑
Dirt, paint, etc on hands	Yes ❑	No ❑
Certain food textures	Yes ❑	No ❑
Having teeth brushed	Yes ❑	No ❑
Having hair brushed	Yes ❑	No ❑
Tags in clothing	Yes ❑	No ❑
Wearing socks or tight clothing	Yes ❑	No ❑
Car sickness	Yes ❑	No ❑
Being touched	Yes ❑	No ❑

Does the child have a normal response to pain?

Is your child what you might call hyperactive (always moving, can't sit still)?

Does your child seem overly lazy (never wants to do any activity)?

ADDITIONAL INFORMATION

Please provide any additional information that might be helpful in the evaluation or remediation of the child's problem.

Person completing form: ____

Relationship to child: ____

Signature: ____ Date: __________________

Please return this packet of information by mail prior to the evaluation, if possible, so the therapists can review the child's history and prepare the necessary evaluation. If it is not possible to return these prior to the evaluation, please bring them the day of the evaluation.

On the day of the evaluation, you will need:

- ✓ Insurance information
- ✓ Prescription from the physician ordering the therapy evaluation (if MD did not fax it directly to Access Rehab Centers.)
- ✓ Copy of Individualized Family Service Plan from school (IFSP) if child has one.
- ✓ Copy of any evaluations done by specialists (psychologist, neurologist, etc.)

The child can not be seen without a valid and current prescription.

When Access Rehab Centers receives authorization from the child's insurance company, sessions can begin. Most insurance companies will give authorization within two weeks of the initial evaluation.

Thank you for taking the time to fill out this important information. Please mail it back us as soon as possible to the address at the top of the first page.

If this is not possible to mail this form, please be sure to bring it with you to the evaluation.

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For Access Rehab Use Only

Reviewed By: ____ _____________
(Therapist Signature) (Date)