Kids CENTER

MAILING ADDRESS
P. O. Box 17630
Louisville, KY 40217

CENTRAL CAMPUS
982 Eastern Parkway
Louisville, KY 40217
(502) 635-6397

EAST CAMPUS
9810 Bluegrass Parkway
Louisville, KY 40299
(502) 584-9781

www.kidscenterky.org

New Patient ___
Current Patient ___

PATIENT INFORMATION

USE INK PEN TO COMPLETE

Date:_____ Person providing information:_____
Relationship to child:_____

Child's Name:_____ **DOB:**_____ **Sex:** _____

1. Reason for Referral:
   _____
   _____

2. What are your main concerns for your child at this time?
   _____
   _____
   _____

3. What skills would you like for your child to improve that are related to **Physical Therapy**?
   □ gross motor □ balance & coordination □ joint mobility □equipment
   □ mobility □ posture □ other _____
   Specific comments:_____

4. If interested in **Occupational Therapy**, please complete attached O.T. questionnaire.

5. If interested in **Speech Therapy**, and/or **Feeding**, please complete Attached S.T. questionnaire.

Previous History

6. **Birth History**
   Hospital:_____ □ Full Term □ Premature How early? _____
   Delivery: □ C-section □ Vaginal □ Birth weight: _____
   Birthing Assistance: □ Forceps □ Suction
   Birth Presentation: □ cephalic (head first) □ breech □ shoulder □ nuchal cord

   Did you or your child experience any problems during your pregnancy or delivery?_____
   _____

   Did he/she require an extended hospital stay after delivery? □yes □no
   How long? _____

   Was your child adopted? □ yes □ no If yes, at what age?_____,
   and from what country?_____

7. **Relevant Medical History**
Please list all diagnoses that your child has:

_____
_____
_____

Does your child have a history of seizures? ◻ yes ◻ no If yes, what type? _____
Does your child have a shunt? ◻ yes ◻ no If yes, what type?_____
Does your child have feeding issues? ◻ yes ◻ no
Does your child have a G-tube ◻ yes ◻ no
Has your child had a swallow study? ◻ yes ◻ no If yes, when & where? _____
Did your child receive newborn hearing screening at birth? ◻ yes ◻ no
Has your child had a hearing test (audiological evaluation)? ◻ yes ◻ no
Has your child been diagnosed with a hearing loss? ◻ yes ◻ no
Does your child wear a hearing aid? ◻ yes ◻ no
Does your child have a history of ear infections? ◻ yes ◻ no
Does your child have ear tubes? ◻ yes ◻ no ◻ previously, but not currently
If previously, when were they placed? _____
Has your child ever had a head injury or concussion? ◻ yes ◻ no If yes, explain what happened and when: _____
Does your child have a Baclofen pump? ◻ yes ◻ no If yes, when was it placed?
_____
What physician did the surgery to place it?_____
Who monitors the dosage?_____
Who does the pump refills?_____

Are your child's immunizations up to date? ◻ yes ◻ no If no, what does he need?

_____

Has your child had any communicable disease? ◻ yes ◻ no If yes, what disease:_____

Other than the above, what other health problems does your child have? (Please describe)

_____
_____

8. Please list all test/procedures, hospitalizations and surgeries that your child has had: (include year and surgeon)

_____
_____

_____

_____

9. **Allergies:** Please list all allergies and/or sensitivities:

_____

_____

_____

_____

10. **Developmental Motor Milestones:**
Please indicate which of the following motor milestones your child has achieved and at what age it occurred:

- ☐ Holding head up_____
- ☐ Rolling_____
- ☐ Sitting alone _____
- ☐ Crawling (belly or hands & knees)_____
- ☐ Pulling to stand _____
- ☐ Cruising (walk at furniture)_____
- ☐ Standing (no external support)_____
- ☐ Walking (no external support)_____

11. **Previous Therapies:** Please list all previous therapies & include approximate date of last visit

_____

_____

_____

_____

12. **Relevant Family History:**
Please list any family members with the same or similar diagnosis as your child:

_____

_____

Other relevant family medical history:_____

_____

Current Profile:

1. Provide Name of other professionals involved with your child:

Pediatrician	
Orthopedist	
Neurologist	
Neurosurgeon	
Physiatrist	
Cardiologist	
Ophthalmologist	
Psychiatrist	
Psychologist	
Chiropractor	
Gastroenterologist	
Pulmonologist	
Audiologist	
ENT	
Allergist	
Dentist	
Nutritionist	
Orthotist (Splints,/Brace Shop)	
Home Health Agency	
Medical Equipment Company	
Endocrinologist	
Geneticist	
School Therapist	
Primary Service Coordinator	
Other:	

Please check any of the following that are currently involved with your child:

- ☐ Commission for Children with Special Healthcare Needs
- ☐ First Steps ☐ Indiana Commission for Children ☐ VIPS ☐ LDOS
- ☐ Green Hill ☐ Aquatherapy ☐ Kosair Neurology Clinic
- ☐ Weisskopf Child Evaluation Center ☐ C.O.O.L. ☐ Home of the Innocents
- ☐ Associates in Pediatric Therapy ☐ Cincinnati Childrens ☐ KORT

2. Medications: Please list all medications, dosage, and reason for medication:

Medication:	Dosage:	For:

What medication side effects are noticed and at what time of day? (if applicable)

_____

_____

3. Planned or scheduled appointments/tests/procedures:
Please list any appointments, tests, &/or medical procedures that are scheduled (when/where)_____

4. Current therapies:
Does your child receive the following therapies **through the school system**? (If yes, please provide frequency and name of therapist)
Speech Therapy ◻ yes ◻ no_____
Occupational Therapy ◻ yes ◻ no _____
Physical Therapy ◻ yes ◻ no _____

Does your child **currently** receive therapy services **(not at school)**? (Provide location, frequency and name of therapist)

Speech Therapy ◻ yes ◻ no

_____
Occupational Therapy ◻ yes ◻ no

_____
Physical Therapy ◻ yes ◻ no

_____

5. Relevant family/home circumstances or routines:
Please list all the people living in your home (include age and relationship to child):

_____

_____

_____

_____

What language is used primarily in your home:_____
What is the preferred language for printed instructions:_____
What type of transportation do you use: ◻ Private ◻ Public Do you have or need a lift?_____

Home Environment: ◻ Stairs ◻ Indoors ◻ Outdoors How many? _____
Railing(s)? _____ ◻ Ramp ◻ Living quarters on how many levels?____

What equipment do you have in your home for your child?
◻ Wheelchair ◻ Stander ◻ Gait trainer ◻ Walker ◻ Braces for legs/feet
◻ Splints for hands ◻ bath seat ◻ special seating:_____
Other:_____

6. **School/Education:** My child **currently** attends: (please enter location & grade if applicable):

- ☐ Day Care_____
- ☐ Preschool _____
- ☐ Kindergarten _____
- ☐ Elementary School/Grade_____
- ☐ Middle School/Grade_____
- ☐ HighSchool/Grade_____