Jaworski Physical Therapy, Inc.

Pediatric Medical History Form

Name of Child		Name of Parent/Legal Guardian:		SSN#
Address:		City:	State	Zip Code
Insurance Cardholder (if different)		Relationship to cardholder		Phone:
Address:		City:	State	Zip Code
Date of Birth	Age	Length of pregnancy	Sex ☐ M ☐ F	APGAR score at birth
Onset of Diagnosis	Referring Physician	Age of Siblings	Grade level	School Attending
If premature list cause if known:				
Note any complications at birth:				
Post Birth Status (oxygen, heart monitor)				
What equipment is used at home:				

Please check if your child has a history of any of the following

- ☐ Cancer
- ☐ Heart Problems
- ☐ Circulation Problems
- ☐ High Blood Pressure
- ☐ Nervous System Disease
- ☐ Cardiac Pacemaker
- ☐ Metal implants (rods, pins etc)
- ☐ Developmental Delay
- ☐ Cerebral palsy
- ☐ Autism
- ☐ Serious Accident
- ☐ Bone Fracture
- ☐ Stroke
- ☐ Muscular disease
- ☐ Lung Disease
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Epilepsy or Seizures
- ☐ Asthma
- ☐ Allergies
- ☐ Depression
- ☐ Mental illness
- ☐ Other: _____

For Therapist Use Only

Do you feel your child has feeding difficulties? ☐ Yes ☐ No
During the past month has your child been more upset or distressed than normal? ☐ Yes ☐ No
During the past month has your child been less active or playful? ☐ Yes ☐ No
Are your child's immunizations up to date? ☐ Yes ☐ No

Please list any surgeries or hospitalizations your child has had (include dates if known): _____

_____

Please list any prescription or non prescription medications you child is taking _____

_____

Does your child have an established IEP from School? ☐ yes ☐ No

Is you child having difficulty in any of the following areas (please check all that apply)

☐ Feeding	☐ Swallowing	☐ Talking
☐ Rolling over	☐ Sitting up	☐ Sitting
☐ Crawling	☐ Kneeling	☐ Standing
☐ Balancing	☐ Walking	☐ Running

☐ Other: _____

I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about my child by Jaworski Physical Therapy, Inc. for the purpose of treatment, obtaining payment for treatment and as necessary in order to carry out any healthcare operations that are permitted to the regulations. I am aware that The Practice maintains a "Privacy Notice" which sets forth the types of uses and disclosures that The Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which The Practice will make such use. By signing this Consent, I understand and acknowledge that I have reviewed the "Privacy Notice" which is attached before signing this Consent.

General: I hereby assign all medical benefits to include Major Medical, Medicare, Private Insurance and other sponsored programs and health plans and I authorize payment of medical benefits to Jaworski Physical Therapy, Inc. I understand that I am financially responsible for all charges whether or not paid to by said insurance and I hereby authorize said assignee to release all information necessary to secure payment of said payment benefits. The assignment will remain in effect until revoked b me in writing.

Permission to take Photograph: I hereby consent ___ or deny ___Jaworski Physical Therapy, Inc. to take a photograph of my child only for the purpose to use in his/her medical chart and will not be disclosed for any other reason without additional permission from me.

_____ _____

Parent/Guardian signature if Minor Date