Pediatrics Rehabilitation

Problem Summary List MRN: _____

Salem Health® Hospitals & Clinics

TO ENSURE THAT YOU RECEIVE A COMPLETE AND THOROUGH EVALUATION, PLEASE PROVIDE US WITH THE IMPORTANT BACKGROUND INFORMATION ON THE FOLLOWING FORM. IF YOU DO NOT UNDERSTAND A QUESTION, YOUR THERAPIST WILL ASSIST YOU. THANK YOU!

PATIENT INFORMATION

First Name: _____ **Last Name:** _____

Age: _____ **Date of birth:** _____ **Gender:** ☐ Male ☐ Female

Who lives at home with the child: _____ **If siblings, what are the ages:** _____

School: _____ **Grades:** _____

Recreational/play activities: _____

Date of onset: _____

Briefly describe the problem your child is here for and how it started: _____

Has your child had other occupational, physical, speech, voice or swallowing therapy? If so, list name of therapist(s) and date(s):

Has your child had any of the following tests for this problem?

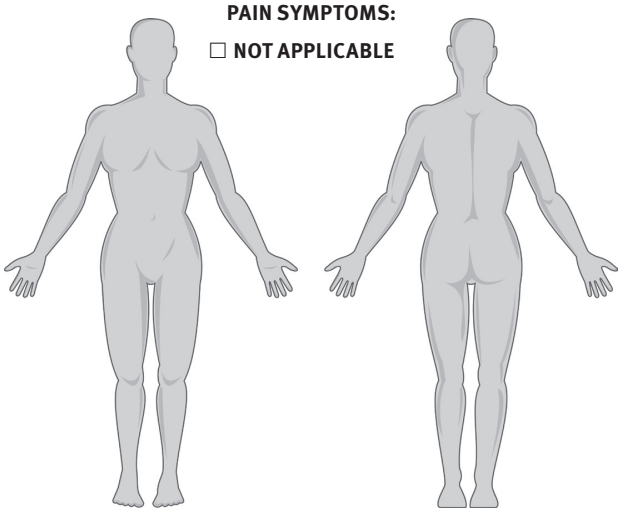
☐ Bone ☐ CT scan ☐ MRI _____

☐ X-ray ☐ Ultrasound

☐ Other: _____

PLEASE MARK THE LOCATION OF YOUR CHILD'S PAIN SYMPTOMS:

☐ NOT APPLICABLE



PLEASE INDICATE THE SEVERITY OF YOUR CHILD'S PAIN NOW, IF ANY: (CIRCLE NUMBER)

0 1 2 3 4 5 6 7 8 9 10

MILD MODERATE SEVERE

If so, please describe results: _____

What are *your* goals for treatment? _____

PLEASE LIST ANY INJURIES, SURGERIES, OR OTHER CONDITIONS FOR WHICH YOUR CHILD HAS BEEN HOSPITALIZED

INJURY	SURGERY	HOSPITALIZED	REASON	APPROXIMATE DATES
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		

PLEASE CONTINUE ON THE REVERSE SIDE.

DSC 432912 (12/17)

Salem Health Rehabilitation Center

Problem Summary List

Salem Health® Hospitals & Clinics

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____

Has your child *ever* been diagnosed as having any of the following conditions?

- ☐ ADHD
- ☐ Anemia
- ☐ Asthma
- ☐ Autism
- ☐ Cancer (describe type): _____
- ☐ Cerebral Palsy
- ☐ Depression
- ☐ Diabetes
- ☐ Fall(s) in the last 30 days
- ☐ Genetic Disorder
- ☐ Headache
- ☐ Hearing loss
- ☐ Heart problems
- ☐ High fevers
- ☐ Juvenile arthritis
- ☐ Kidney trouble
- ☐ Measles
- ☐ Nerve/Muscle disease
- ☐ Pneumonia
- ☐ Prematurity
- ☐ Psychiatric disorder
- ☐ Ulcers/heartburn
- ☐ Seizures
- ☐ Stroke
- ☐ Vision loss
- ☐ Other: _____

Please list known allergies and reactions:

- ☐ No known allergies
- ☐ Latex
- ☐ Tape/adhesive
- ☐ Skin allergies: _____
- ☐ Medications: _____
- ☐ Food allergies: _____
- ☐ Other: _____

If your child has been treated by any of the below providers in the past three months for any reason (illness, medical condition, physical exams, etc.), please check:

- ☐ Audiologist
- ☐ Dentist
- ☐ Developmental Pediatrician
- ☐ Early intervention
- ☐ Emergency Room
- ☐ ENT
- ☐ Medical doctor (MD)
- ☐ Naturopath
- ☐ Neurologist
- ☐ Osteopath (DO)
- ☐ Physical/Occupational Therapist
- ☐ Psychiatrist /psychologist
- ☐ Speech Therapist
- ☐ Other: _____

_____

Has your child had a hearing or vision test? If yes, what were the results? _____

_____

_____

_____

Please return this form and medication list to your child's therapist.

_____
Therapist's Signature

_____
Date/Time

_____
Parent/Guardian's Signature

_____
Date/Time

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