SPARTANBURG REGIONAL REHABILITATION SERVICES
PEDIATRIC PATIENT HISTORY

PATIENT NAME:____ DOB:___________________

Why was your child referred?:____
____

What would you line your child to gain from services here? _ SPARTANBURG REGIONAL REHABILITATION SERVICES
PEDIATRIC PATIENT HISTORY ____
____

MEDICAL HISTORY

Please list any Surgeries/Illnesses that have required hospitalization.

Date/Age of Child	Reason for Hospitalization/Surgery

CONDITIONS

☐ Ear Infections How many?____________	☐ Colds
☐ Sinusitis	☐ Reflux
☐ Seizures	☐ Prematurity
☐ Other	☐ Other

ALLERGIES

☐ No known allergies of any kind	☐ Medicine ______________________________
☐ Food _________________________________	☐ Seasonal/Environmental ________________
☐ Latex ________________________________	☐ Adhesive ______________________________
☐ Other ________________________________	☐ Other __________________________________

MEDICATIONS

1.	2.
3.	4.
5.	6.

PRECAUTIONS

☐ Seizures	☐ Feeding Tube
☐ Weight Bearing Status	☐ Swallowing Precautions
☐ Other	☐ Other

PHYSICIANS/PROVIDERS

TYPE	NAME	REASON
☐ Pediatrician		
☐ Family Physician		
☐ Neurologist		
☐ Ophthalmologist		
☐ Ear Nose & Throat		
☐ BabyNet		
☐ Early Intervention		
☐ Mental Health		
☐ Other		
☐ Other		

OTHER SERVICES

Is your child currently receiving therapy?		☐ Yes	☐ No
Has your child received therapy in the past?		☐ Yes	☐ No
Please Check all that apply	☐ OT	☐ PT	☐ SLP
☐ Home	☐ School _______________________	☐ Other Clinic ___________________________	

Signature of Parent/Legal Guardian ____________________________________ Date _____________________