Name: _____ Date of Birth: _____ Today's Date: _____

Physician: _____ Onset Date: _____

Reason(s) for coming to PT / OT / SLP: _____

Have you had any tests recently? *For example, X-Ray, CT scan, MRI, EMG, ECG, etc.?* ❑ No ❑ Yes ➔ Explain: _____

Does your child have any hearing or Visual deficits? ❑ No ❑ Yes ➔ Explain: _____

Does your child have difficulty following direction or staying on task? ❑ No ❑ Yes ➔ Explain: _____

Does your child have difficulties at school? ❑ No ❑ Yes ➔ Explain: _____

Does your child have difficulty with speech or feeding? ❑ No ❑ Yes ➔ Explain: _____

Do you have any concerns about your child's development? ❑ No ❑ Yes ➔ Explain: _____

Does your child complain or show signs of pain or discomfort? ❑ No ❑ Yes ➔ Where is the pain? _____

What activities make the pain better? _____

What activities make the pain worse? _____

Does your child have any known orthopedic problems? ❑ No ❑ Yes ➔ Explain: _____

What are your goals for your child while receiving therapy? _____

➔➔➔ OVER ➔➔➔

Past Medical History: Do you have ANY previous history of the things listed below?

CONDITIONS:	YES	NO	CONDITIONS:	YES	NO
Toe Walking / Club Feet			Baclofen Pump		
Heart Condition			Seizures		
Brain Hemorrhage (what grade?)			Cancer		
Hip Dysplasia			Shortness of Breath		
Diabetes			Asthma		
Dizziness			Persistent Night Pain		
Light Headedness			Frequent/Severe Headaches		
Excessive Fatigue			**Unexplained** Weight Loss		
Broken Bones (fractures)			Failure to Thrive		
Cleft Palate			Incontinence		
ADHD			Amputation		
Sensory Processing Disorder			Cerebral Palsy		
Autism			Developmental Delays		
Birth Defect			Other:		

Staff Initials	Date	Time	ALLERGIES Do you have any allergies? ☐ No ☐ Yes, please list:	REACTION(S)

Staff Initials	Date	Time	OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS Do you have any other diagnoses &/or significant conditions? ☐ No ☐ Yes, please list:

Staff Initials	Date	Time	PREVIOUS PROCEDURES / SURGERIES Do you have any previous procedures or surgeries? ☐ No ☐ Yes, please list:

Staff Initials	Date	Time	CURRENT MEDICATIONS ☐ See attached list of medications that the patient provided. Are you currently taking any medications, including herbals? ☐ No ☐ Yes, please list:

INITIALS	STAFF SIGNATURE	INITIALS	STAFF SIGNATURE

PATIENT SIGNATURE: _____ **DATE:** _____ **TIME:** _____

Olathe Medical Center
20333 West 151st Street
Olathe, Kansas 66061

OUTPATIENT PT-OT-SLP PEDIATRIC INTAKE QUESTIONNAIRE & OUTPATIENT SUMMARY

10.10.2013; Rehab

O.M.C. No. 2081

PLACE PATIENT LABEL HERE