To be completed by, the patient/parent/guardian:

Patient Name: _____ Date: _____

Date of Birth: _____ Parent/Guardian's Name: _____

Parent/Guardian's Phone Number: *Home:* _____ *Work:* _____ *Cell:* _____

Emergency Contact Name (other than parent/guardian): _____ Phone: _____ Attn #: _____

Pediatrician's Name: _____ Phone Number: _____

1. The patient is able to communicate in: ❑ English ❑ Spanish ❑ French ❑ Creole
   ❑ Sign language ❑ Other _____ ❑ Interpreter _____
2. The parent/guardian is able to communicate in: ❑ English ❑ Spanish ❑ French ❑ Creole
   ❑ Sign language ❑ Other _____ ❑ Interpreter _____
3. Does the patient have any religious, cultural, or spiritual practices that may alter their care or education? ❑ Yes ❑ No
   Please describe: _____
4. Do you have any financial concerns regarding the patient's therapy? ❑ Yes ❑ No
   If yes, please describe: _____
5. Describe the reason your child needs therapy: _____
   _____
6. What are the patient/family expectations/goals from therapy? _____
7. Has the patient ever received or is currently receiving treatment for this problem? ❑ Yes ❑ No
   Please describe: _____
8. Does the patient have any special needs and/or nutritional needs or concerns? ❑ Yes ❑ No
   If yes, what are they? _____
9. Does the patient have all of the vaccinations/immunizations for their age? ❑ Yes ❑ No
   If no, why? _____
10. Who do you consider family & who can we include in your care? _____
11. Who may we share your medical / rehabilitation progress with? _____

Medical History

Has the patient ever had, or do they currently have any of the following conditions? Check Yes or No, and indicate the dates as accurately as possible:

Medical Condition	Yes I've had	No I have not	If Yes, Dates of Occurrence	Medical Condition	Yes I've had	No I have not	If Yes, Dates of Occurrence
Attention Deficit Disorder or Attention Deficit / Hyperactivity Disorder				Hernia			
				Hydrocephalus			
				Irregular Heartbeat			
Apnea / Bradycardia				Muscular Dystrophy			
Asthma							
Autism				Open Wounds			
Bowel/Bladder Problems				Prematurity			
				Pervasive Developmental Disorder			
Brain Injury							
Cancer				Psychiatric Care			
Chemotherapy				Radiation Therapy			
Diabetes				Reflux			
Difficultly Breathing				Seizures			
Ear Infections				Skin Problems			
Epilepsy				Stroke			
Fractures				Surgery			
Heart Disease/Defect				Tuberculosis			
				Ventricular Peritoneal Shunt			
Hepatitis				Other:			

12. Has the patient had surgery? ❑ Yes ❑ No If yes, please give types and dates for the procedures? _____
    _____
13. Please list allergies: ❑ None _____
14. Is the patient following any precautions? Has the patient been told things to avoid? ❑ None ❑ Yes
    (Please list): _____

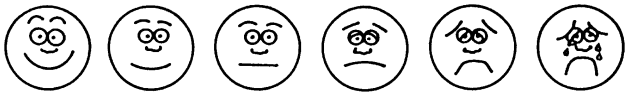
Medications

1. Please list all the medications the patient is currently taking ❑ None _____

2. Please list all over the counter medications and supplements the patient is currently taking ❑ None _____

Pain Management

1. Does the patient have any pain? ❑ Yes ❑ No
2. Has the patient had any pain recently? ❑ Yes ❑ No If yes, when _____
3. Severity of pain (please use the scale BELOW to determine the patient's levels)



0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

Current pain level: _____
Pain level at best: _____
Pain level at worst: _____

FLACC PAIN SCALE

Use for children < 3 years of age
Score each category by chosing 0, 0.5, or 1 fora total score range of 0 - 5

Categories	0	0.5	1
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

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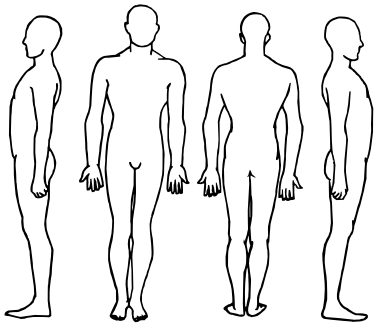
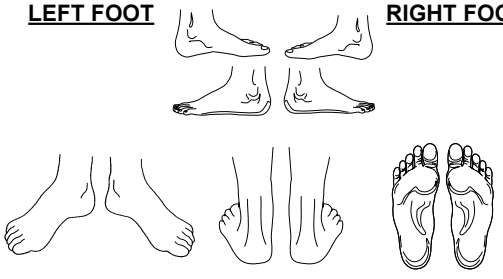
4. When did the pain start? _____
5. Duration of pain: ❑ Constant ❑ 75% of the time ❑ 50% of the time ❑ 25% of the time
6. What kind of pain is the patient feeling? ❑ Aching ❑ Burning ❑ Crushing ❑ Dull ❑ Excruciating
   ❑ Pressure ❑ Sharp ❑ Stabbing ❑ Stiffness ❑ Throbbing
   ❑ Unable to describe ❑ Other _____
7. What aggravates the pain? _____ What decreases the pain? _____
   Is it effective: ❑ all of the time ❑ most of the time ❑ some of the time
   ❑ temporary relief ❑ not effective
8. Location of the pain (indicate location with an X) Does the patient's pain travel or radiate from one part of the body to another? ❑ Yes ❑ No



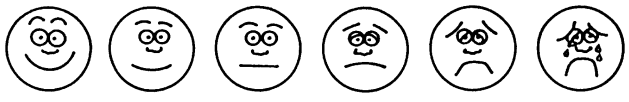
LEFT FOOT **RIGHT FOOT**



Memorial Healthcare System
Joe DiMaggio Children's Hospital
OUTPATIENT REHABILITATION
PEDIATRIC PATIENT INFORMATION

PATIENT/LABEL

9. Circle what is an acceptable pain level for the patient upon **completion** of their therapy?



0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

FUNCTIONAL INFORMATION

*Check **all** the activities that the patient is currently able to perform:*

- ❑ Holds head steady
- ❑ Reaches for toys
- ❑ Holds toys
- ❑ Rolls
- ❑ Sits
- ❑ Crawls
- ❑ Claps/bangs
- ❑ Scribbles / writes
- ❑ Stacks
- ❑ Pulls up to stand
- ❑ Walks
- ❑ Climbs
- ❑ Runs
- ❑ Hops/skips/jumps
- ❑ Swings self on swing
- ❑ Rides bike
- ❑ Imitates/repeat words
- ❑ Expresses self
- ❑ Says 1-2 words
- ❑ Says sentences
- ❑ Answers simple questions
- ❑ Answers complex questions
- ❑ Speaks clearly
- ❑ Follows simple commands
- ❑ Holds bottle/cup
- ❑ Takes food from a spoon
- ❑ Drinks from a cup
- ❑ Finger feeds
- ❑ Undresses self
- ❑ Dresses self
- ❑ Bathes self
- ❑ Ties shoes

EDUCATION

1. How does the patient/parent/guardian learn best? ❑ Written ❑ Visual/demonstration ❑ Verbal ❑ Other _____
2. Highest level of education the patient/parent/guardian has completed? _____
3. Highest level of education the patient has completed? _____
4. The patient/parent/guardian would like to learn about: ❑ home exercise program ❑ pain management techniques ❑ support groups ❑ Other: _____

I, the patient, parent or guardian, have provided accurate information to the best of my knowledge and have received orientation to Outpatient Rehabilitation. I have read and understand them. It is my responsibility to advise the therapist of any unexpected changes in the patient's condition, medication, or additional treatments the patient is receiving. I will actively participate in the decision making process and be involved in the patient's treatments. I will express any concerns I have to the therapist. I acknowledge that I am responsible for the patient's outcome, if I, the parent or guardian, do not comply with the treatment plan. I, the parent or guardian, permit the Hospital to disclose Privileged Health Information to the person dropping the child off or picking the child up.

Patient / Parent / Guardian
(please circle) Signature: _____ Date: _____

To be completed by the therapist with the patient/parent/guardian:

Education Needs: To be completed with the therapist:

- ❑ ADL/Functional Training
- ❑ Body Mechanics
- ❑ Bowel/Bladder Diary
- ❑ Communication
- ❑ Community Resources
- ❑ Diagnosis
- ❑ Discharge Planning
- ❑ Gait Training
- ❑ Home Exercise Program
- ❑ Home Modifications
- ❑ Medical Equipment
- ❑ Mobility
- ❑ Newborn Care
- ❑ Nutrition
- ❑ Occupation
- ❑ Pain Management
- ❑ Posture
- ❑ Prevention
- ❑ Self Mobilization Techniques
- ❑ Wound Care
- ❑ Voiding
- ❑ Other _____

Pregnancy / Labor: _____

Tests: _____

PMH: _____

Social / Home / School Environment: _____

Adaptive Equipment: _____

Potential barriers to learning are: ❑ age ❑ financial ❑ cognitive ❑ religious ❑ physical
❑ level of education ❑ communication ❑ cultural beliefs/values ❑ none

Signs and symptoms of abuse or neglect noted: ❑ Yes ❑ No
If yes what action was taken: _____

Admission Packet Issued: ❑ Yes ❑ No If no, reason _____

❑ Fall Prevention Program Initiated

	Therapist's Signature	Therapist's ID #	Date Eval Initiated
Physical Therapist			
Occupational Therapist			
Speech Language Pathologist			