PEDIATRIC ON-BOARDING FORM A

Date: _____

Child's Name: _____
Last First Middle

Child's Current age: ___years ____ months **Date of birth:** __/__/

Gender: ☐ Male ☐ Female ☐ Other

Siblings: ☐ Yes ☐ No If yes:
Number of siblings: _____ **Ages of siblings:** _____

Attends: ☐ School ☐ Home school ☐ Preschool ☐ Daycare

AREAS OF CONCERN

Please check the following areas of development where you have concerns:

Speech: ☐ Yes ☐ No

Fine motor (coloring, writing, cutting): ☐ Yes ☐ No

Gross motor (rolling, crawling, walking): ☐ Yes ☐ No

Has this child ever received therapy services? *Please circle*– Yes or No
If so, what services:

Speech Where: _____How long: _____
Occupational Where: _____How long: _____
Physical therapy Where: _____How long: _____

What are your goals for therapy at this time?

MEDICAL HISTORY

Birth Weight: _____lbs. _____oz.

Term: ☐ Full or ☐ Premature: If so, how many weeks early?_____

Delivery: ☐ Vaginal ☐ C-section

Presentation: ☐ Anterior (Typical) ☐ Breech ☐ Posterior (Face Up)

Birth complications: ☐ Yes ☐ No

Required Oxygen? ☐ Yes ☐ No

Intubated? ☐ Yes ☐ No

NICU stay? ☐ Yes ☐ No
If so, how long?_____

Other birth complications_____

Has any **illness, injury, or accident** occurred that may have impacted your child's development?
If so, please explain and say when: _____

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Does your child have frequent ear infections: ☐ Yes ☐ No
If yes, how often? _____

Does your child have ear tubes? ☐ Yes ☐ No
If yes, when were they placed? _____

Date of last hearing screening:_____ Results: _____

Does your child have any of the following **medical diagnoses**?

- ☐ Abdominal/Stomach Issues
- ☐ ADHD/ADD
- ☐ Asthma
- ☐ Asperger
- ☐ Autism
- ☐ Behavioral/Emotional Disorders
- ☐ Breathing Problems
- ☐ Cerebral Palsy
- ☐ Congenital Heart Disease
- ☐ Diabetes
  Type _____
- ☐ Digestive Issues
- ☐ Down Syndrome
- ☐ Excessive Fatigue
- ☐ Head Injury/Concussion
- ☐ Hearing Loss
- ☐ High Blood Pressure
- ☐ Muscular/Skeletal Conditions
- ☐ GERD
- ☐ Seizures
- ☐ Sleep Disorders
- ☐ Vision Problems/Glasses

Please list details AND any other medical conditions not mentioned above:
_____
_____
_____

Does your child have any **allergies**? ☐ Yes ☐ No
If so, please list: _____

Has your child been been **hospitalized**? ☐ Yes ☐ No

Has your child had any **surgeries or procedures**? ☐ Yes ☐ No
If Yes,
Date:_____
Reason:_____
Date: _____
Reason:_____

Current medications: