

PATIENT INFORMATION SHEET

Child's Name: _____ DOB: _____

Address: _____

Phone Number: _____

Pediatrician's name, address, phone number:

Sub-specialist your child sees:

FAMILY INFORMATION

Mother's Name: _____ DOB: _____

Mother's Address: _____

Home Phone #: _____ Work Phone #: _____

Mother's Occupation: _____

Father's Name: _____ DOB: _____

Father's Address: _____

Home Phone #: _____ Work Phone #: _____

Father's Occupation: _____

LEGAL GUARDIAN INFORMATION

Name: _____

Address: _____

DFACS Caseworker Name: _____

County: _____ Phone #: _____

Supervisor's Name: _____ Phone #: _____

MEDICAL HISTORY (continued)

List any HOSPITALIZATIONS your child has had.

Date of Hospitalization	Reason for Admission	Name of Hospital

List any SURGERIES your child has undergone

Date of surgery	Procedure	Name of Hospital	Name of Doctor

Does your child receive any of the following therapies?

THERAPY	Number of times per week	Location
Speech Therapy (ST)		
Occupational Therapy (OT)		
Physical Therapy (PT)		
Other		

FAMILY HISTORY

Is there a FAMILY history of any illness or disease? _____ If YES, please describe: _____

SIBLING HISTORY

List name, age, and health problems of child's brothers and sisters

Name	DOB	Health Status

PAIN HISTORY

Is your child currently experiencing pain? Yes No

Location of pain: _____

Please indicate the level of present pain on the following scale:

No Pain Intolerable
0 1 2 3 4 5 6 7 8 9 10